MASS.
HF40.2:
T69

UMASS/AMHERST
312066 0282 4081 3

U OF MASS/AMHERST LIBRARY

Transition Plan for the Separation of the Department of Mental Health

JUN 15 87
MASSACHUSETTS
DEPOSITORY COPY

fis·sion \'fish-ən, 'fizh-\ *n*
1: a splitting or breaking up into parts **2:** the splitting of an atomic nucleus resulting in the release of large amounts of energy

March 1, 1987

Digitized by the Internet Archive
in 2014

https://archive.org/details/transitionplanfo00mass

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

ARD M. MURPHY
Commissioner

AREA CODE (617

February 27, 1987

JUN 15 87

The Honorable Patricia McGovern, Senate Chairman
The Honorable Angelo Scaccia, House Chairman
Special Commission on the Separation of
the Department of Mental Health
State House
Boston, MA 02133

Dear Senator McGovern and Representative Scaccia:

As required by Chapter 599 of the Acts of 1986, we are submitting the attached transition plan describing the process by which the Department of Mental Health will separate into two new agencies during fiscal year 1988. This plan is offered in the hope that the Special Commission will find it to be a useful blueprint for the complex task that lies ahead.

This plan reflects the best current judgment of many people in the mental health and mental retardation community. The plan was prepared on a tight schedule, however, and we are confident that knowledgeable review by members of the Special Commission will improve the process and provide valuable guidance for the implementation. This plan does not represent the final word on the development of two new agencies, but we hope that it provides a framework within which we can manage a dynamic process of change.

The Commonwealth's mental health and mental retardation systems have arrived at an historic moment. After decades of joint administration, the two fields will go their separate ways. This crossroads evokes mixed feelings among professionals, clients, family members, and other citizens. In spite of problems, the current DMH has done a great deal of good during its long existence. Change of the magnitude we now confront is daunting, but the chance for dramatic improvement is clearly before us. Initiatives by Governor Dukakis and the legislature have created a firm resolve to improve mental health services. The recent ending of federal court supervision over the mental retardation institutions demands that the Commonwealth focus new

attention on planning how retardation policy should evolve in the future. The split comes at an opportune time to take advantage of these events. Managed correctly, the split will release a tide of creative energy that will propel our services to mentally ill and retarded citizens to a new level of quality and comprehensiveness.

We look forward to working with you during this exciting transition.

Sincerely,

Edward M. Murphy
Commissioner

Philip W. Johnston, Secretary
Executive Office of Human Services

TABLE OF CONTENTS

CHAPTER ONE
THE CURRENT DEPARTMENT OF MENTAL HEALTH 1

CHAPTER TWO
THE NEW DEPARTMENT OF MENTAL RETARDATION..... 6

CHAPTER THREE
THE NEW DEPARTMENT OF MENTAL HEALTH..... 14

CHAPTER FOUR
SERVICES FOR DUAL-DIAGNOSED AND SPECIAL NEEDS CLIENTS 24

CHAPTER FIVE
PROPOSED REGION/AREA CONFIGURATION..... 34

CHAPTER SIX
PLAN FOR SEPARATING PERSONNEL AND INVENTORY..... 38

CHAPTER SEVEN
TRANSITION SCHEDULE..... 45

CHAPTER EIGHT
FINANCIAL FORECAST..... 47

EXECUTIVE SUMMARY

The legislation which separates DMH into two departments offers an unparalleled opportunity to develop new organizations which renew the Commonwealth's commitment to quality services whether they occur in the community or in state institutions. Recommendations contained in this Transition Plan strive to build systems that support creative service delivery and encourage management accountability.

New Department of Mental Retardation

The new Department of Mental Retardation is charged with a mission to consider all matters affecting the welfare of mentally retarded citizens. The planned agency structure has three administrative tiers:

- 25 local service centers carry out client-related functions;
- Six regional offices coordinate administrative and management functions including program development, quality assurance, and contracting;
- A central office provides direction and assistance on Department priorities and initiatives, as well as direct oversight for state institutions.

This design supports a client-centered system of care and avoids such historical area-related problems as inequitable resource distribution and gaps in services.

The Department of Mental Retardation defines its priority clientele as present clients, waiting-list clients, those inappropriately in state hospitals and CMHCs and special populations such as those "Turning 22." The new Department will continue the present range of services including residential, day and support programs. The new Department will also develop emergency service programs for dual-diagnosed clients.

New Department of Mental Health

The primary mission of the reorganized Department of Mental Health is to deliver high quality treatment and follow-up to citizens with long-term or serious mental illness, to provide early and ongoing treatment for mental illness, and conduct research into its causes.

The organization design best suited to accomplish this mission is a three-tiered system of area, regional, and central offices.

- 23 area offices are focal points of service delivery, responsible for case management, service plan development, service coordination, program monitoring, and community relations.

- Six regional offices ensure that standardized services exist through planning, monitoring, licensing, and quality assurance functions. Current service bureau functions, such as contracting, will be performed at the regional level in addition to program planning for low-incidence populations.

- A central office manages the hospital system, develops policy and regulatory standards, conducts planning and public education, and supports the area service systems through research, training and technical assistance.

Citizen Participation

The commitment of the current department to citizen involvement is carried forth into the two new departments. Formal citizen participation is structured at each level of both of the new departments to advise on client needs and to shape service development. Citizen advisory capacities are developed in a similar manner in each department:

- Statewide Advisory Councils will be composed of 15 citizens including representatives of each region, and will be appointed by the Secretary of Human Services;

- Regional Advisory Councils will be composed, at a minimum, of two representatives from each local service area;

- A Board of Trustees for each state school and state hospital will be appointed by the Governor. A majority of members should be consumers and family members;

- Local Advisory Councils (DMR) will be composed of 15 local citizens to advise on local needs and services; and

- Area Boards (DMH) will be composed of 15 local citizens to advise on area needs and services.

Both DMR and DMH will encourage the development of these and other citizen advisory mechanisms by offering leadership development, public information, and recruitment of citizen volunteers.

Clinical Issues

The separation of DMH creates special concern for clients with a dual-diagnosis of mental illness and mental retardation. These clients require ongoing collaboration and planning between the new agencies. Although the Department of Mental Retardation is charged with primary responsibility for these clients, each agency should agree that:

- Dual-diagnosed clients will have access to services in both agencies;
- As separate agencies, DMR and DMH must develop a fuller array of clinical and rehabilitative services and formulate an interdisciplinary approach;
- The DMH role will be to provide community and inpatient mental health services and DMR will develop a specialty in emergency and evaluation services for people with mental retardation;
- DMR is responsible for ongoing service coordination and program development, especially emergency care, respite, and residential services;
- Both agencies have a special responsibility for children with dual-diagnosis. Attention should be given to ensure that appropriate agency links to EOHS, DPH, DSS, and DOE are present at each tier; and
- DMR and DMH are jointly responsible for program planning, research, program evaluation, and training for the dual-diagnosed population. Each agency will have specific clinical resource teams at each level.

Fiscal

The costs associated with separation of the Department are anticipated to be approximately $15 million phased in over a three-year period.

PREFACE

Since its creation in 1919, the Massachusetts Department of Mental Health has cared for both mentally ill and mentally retarded persons, two populations with distinct program needs. In December of 1986, the Legislature and Governor Dukakis, acknowledging these important differences, enacted legislation calling for the establishment of a separate Department of Mental Retardation.

Among other provisions, the legislation requires that, by March 1, 1987, the Commissioner of Mental Health submit a transition plan governing the proposed separation of mental health and mental retardation functions. The law envisions that complete separation will occur no later than July 1, 1988. The law also requires the appointment of a Commissioner of Mental Retardation by the Secretary of Human Services by July 1, 1987, enabling collaboration by the Commissioners of DMH and DMR in the transition process. The following Transition Plan is submitted as the first step in a transition process that will result in the estabishment of two organizations, each with the capacity to deliver the best possible services.

The establishment of separate Departments of Mental Health and Mental Retardation represents the culmination of many years of work by clients, parents, advocates, legislators, clinicians, administrators, and others whose dreams of independent agencies responsive to their unique concerns are approaching reality. The clarification of mission and prioritization of client populations resulting from the separation will have a significant positive effect on the delivery of both mental health and mental retardation services.

FOREWORD

FRAMING OF THE PLAN

The Transition Plan builds on the work of six committees established to analyze the problems associated with splitting of the Department of Mental Health into two separate agencies. Mental Health and Mental Retardation Committees concentrated on issues of client identification and characteristics, program and service development and delivery, special populations, organizational structure and responsibilities, and citizen participation. A Clinical Services Task Force focused on those services and clients for which the two departments will have shared responsibility once the separation occurs. Three additional committees were formed to develop recommendations in the areas of personnel, inventory, and budget.

The six committees were aided in their efforts by numerous departmental employees, advocates, professional associations, vendors, and representatives of other governmental agencies, who provided advice in a variety of forums, including:

- The Mental Retardation and Mental Health Committees received feedback on their recommendations at several points during the planning process from advisory groups convened for that purpose.

- The DMH Commissioner held seven well publicized regional meetings to inform the public about the status of planning efforts and to solicit advice.

- The DMH Statewide Advisory Committee (SAC) held seven hearings in December. The information received was used to develop a position paper on the separation.

- Four statewide meetings with DMH staff were held to engage them in the planning process. More than 130 managers attended these day-long sessions.

- A large volume of written suggestions, analyses and comments were received by the Commissioner. These materials were forwarded to appropriate committees for their consideration.

- A split hotline (1-800-22-SPLIT) and split newsletter were established to aid both rumor control and information dissemination efforts. The hotline number was contained in press releases which were sent to 350 publications statewide. The "SPLIT NEWS" was published every 10 - 14 days. More than 5,000 copies were distributed throughout the state. These two initiatives will continue during the transition period.

- Additional meetings and briefings were held periodically to keep interested groups informed and involved.

Drawing upon this wide variety of resources, the committees prepared proposals to the Commissioner for review and possible submission to the Special Commission. The many DMH employees and other citizens of the Commonwealth who offered their critiques and expertise in reviewing drafts were an invaluable part of the process. Their efforts are greatly appreciated.

CHAPTER ONE

THE CURRENT DEPARTMENT OF MENTAL HEALTH

The Department of Mental Health has operated as the state agency responsible for providing services to mentally ill and mentally retarded citizens since 1919. Over the years, service to these two populations has become separate and specialized, while management has remained in a single entity. As the department begins the process of separation, the mission, structure and services of the current organization must be re-examined.

Currently, DMH administers a budget of over $755 million (FY87). As Table 1-1 illustrates, more than 53 percent of the department's budget is allocated to mental retardation services, while more than 42 percent or approximately $320 million provides services to the mentally ill. Approximately 4 percent of the budget is allocated to generic administration.

The department directly operates 12 Community Mental Health Centers (CMHCs), seven hospitals for the mentally ill, seven residential facilities for the mentally retarded, a psychiatric inpatient facility for children, and a treatment program for sexually dangerous persons. In addition, the department contracts with 494 private community agencies for $269.8 million in community services for mentally ill and mentally retarded adults and children. Much of the department's budget funds state and provider agency staff who care for clients in state-operated facilities and community programs across the state. The department employs 19,000 state staff and approximately 10,000 staff through purchase of service contracts with community providers. Table 1-2 illustrates where state staff are deployed among department facilities and programs.

The services of the department are targeted primarily at persons whose functioning is severely impaired as a result of mental illness or mental retardation. These individuals include persons with chronic mental illness, homeless mentally disabled persons, mentally retarded persons living in state facilities and in the community, persons who are diagnosed as mentally ill and mentally retarded, and emotionally disturbed children. Table 1-3 provides information on the numbers of clients served in various service types.

Services

As Table 1-3 indicates, the department provides a range of services for mentally ill persons, including intensive inpatient treatment, residential and day services, case management services, and outpatient therapy. In addition, the department provides a variety of other services including vocational programs, social clubs and emergency/crisis intervention. These services are designed to meet the array of needs of mentally ill children and adults, both when hospitalization is required and when housing and supportive services in the community are required.

The needs of mentally retarded persons are met with a range of comparable services. As Table 1-3 indicates, mental retardation services include residential services at state schools and regional centers as well as in the community, in group homes and Intermediate Care Facilities (ICF-MRs). In addition, day programs, sheltered workshops, case management, service coordination, and various support services such as transportation are provided. Mentally retarded persons who require emergency psychiatric services or psychiatric inpatient hospitalization receive these services through the mental health system. The focus of mental retardation programs is to foster client development and habilitation within the most appropriate community or institutional setting.

Organization

The department's mental health and mental retardation services are provided through a network of forty service areas. Each service area is managed by an Area Director assisted by mental health, mental retardation, and children's service coordinators. Area staff are responsible for needs assessment, program development, monitoring and evaluation. In areas with state-operated CMHCs, Area Directors also function as facility superintendents and oversee the operations of all CMHC programs. Area Directors who do not operate CMHC inpatient units must develop affiliation agreements with the Chief Operating Officer of the appropriate state hospital which provides inpatient services. Finally, all Area Directors must develop appropriate linkages and working agreements with other local state and community agencies.

The state's forty areas are characterized by several different forms of service delivery. These include some areas where services are primarily delivered by state employees and other areas where services are almost entirely purchased from private agencies. In addition, some areas rely to a large extent on a "partnership model," whereby state employees are assigned to work in community service agencies.

The service areas are aggregated into seven districts. Outside of Boston, Area Directors report directly to central administration through District Managers, who provide

administrative and communication links between area and central management. In Boston, Area Directors report to a director of Boston services, who in turn reports directly to the Deputy Commissioners for Mental Health and Mental Retardation.

Central office complements area responsibilities by providing both support and management functions. The Deputy Commissioner for Mental Retardation Services oversees operation of the seven mental retardation facilities, develops policies, and implements community programs in conjunction with local mental retardation coordinators. The Deputy Commissioner for Mental Health Services oversees four program divisions with distinct responsibilities. These are Hospital Management, Forensic Mental Health, Child-Adolescent Services, and Community Programs and Operations. Each division provides technical assistance and program development guidance within their respective program areas. The division of Hospital Management oversees the seven state hospitals, Gaebler Children's Center, and Bridgewater Treatment Center.

In addition to program responsibilities, primary central office functions include legal and regulatory services, investigations and legislative liaison activities, fiscal services, management information functions, system planning, and human resource management. Client advocacy, quality assurance, and interagency collaboration activities occur at all organizational levels of the department.

Citizen Participation

Citizen participation in the planning, development, delivery and evaluation of departmental services takes many forms. At the area level, the Area Director and his or her staff receive advisory assistance from a 21-member citizen board. Membership is limited to persons who live and/or work in the service area and may include clients, family members, guardians, and other interested persons. Area Boards are responsible for advising Area Directors regarding local needs and resources and assisting in the development of comprehensive area plans.

In addition to Area Boards, each provider agency is required to have a governing or advisory board and to establish, impanel and empower Human Rights Committees for its DMH-funded programs. Agency governing boards must include consumers, family members and guardians of consumers as well as citizens from the agency's local community. Human Rights Committees are composed of five or more members, of whom three must be advocates, consumers, parents or guardians of consumers. Not more than one member may have a direct or indirect financial or administrative interest in the program or the Department of Mental Health. The responsibilities of Human Rights Committees are to review, monitor and investigate program activities with regard to clients' human and civil rights.

At the facility level, seven member Boards of Trustees are appointed by the Governor to oversee hospital and school operations in an advisory capacity to Chief Operating Officers and Superintendents. Additionally, advisory committees have formed in a few of the districts to work on issues which affect more than one local area or the district as a whole.

At the state level, the formal citizen input mechanism is the State Advisory Council, which has subcommittees on mental health and mental retardation. This body of 30 members is appointed by the Governor and consists of Area Board representatives, professionals from various mental health and mental retardation fields, and other interested citizens. This Council is responsible for advising the commissioner on budget and policy issues, program development, and prioritization of needs in the state.

In addition to the formal citizen participation mechanisms at the various operational levels of the department, there are also a number of formal and informal professional advisory groups at the secretariat, central and operational levels. One such group prepared the Mental Health Action Plan, which became a foundation for the Governor's Special Message. All the citizen advisory mechanisms are valuable to the department because of the expertise, experience, and perspective that they bring to departmental planning, implementation, and evaluation activities.

Transitional Challenges

The department brings to the transition plan a number of organizational strengths and weaknesses developed over the course of its 70 year history. For both the mental retardation and the mental health service systems, promising recent developments must not be lost in the planning for new agencies. These include: 1) the significant improvement of mental retardation services resulting from consent decrees that have governed the five state schools for the last decade; 2) the Governor's Special Message on Mental Health and its first year support by the Legislature; 3) the accomplishments toward development of a comprehensive community mental health system as a result of the Brewster Consent Decree.

At the same time, a great many challenges remain which the new agencies must address. The new DMR must continue to develop capacity to serve persons in state hospitals awaiting community placement, on waiting lists, low-incidence populations, and dual-diagnosed clients. The needs of mentally retarded children must be addressed through effective interagency collaboration. The state school and community service systems must continue to work together to ensure that all clients achieve their maximum level of functioning. Finally, systems must be developed which monitor performance and ensure effective and accountable program management.

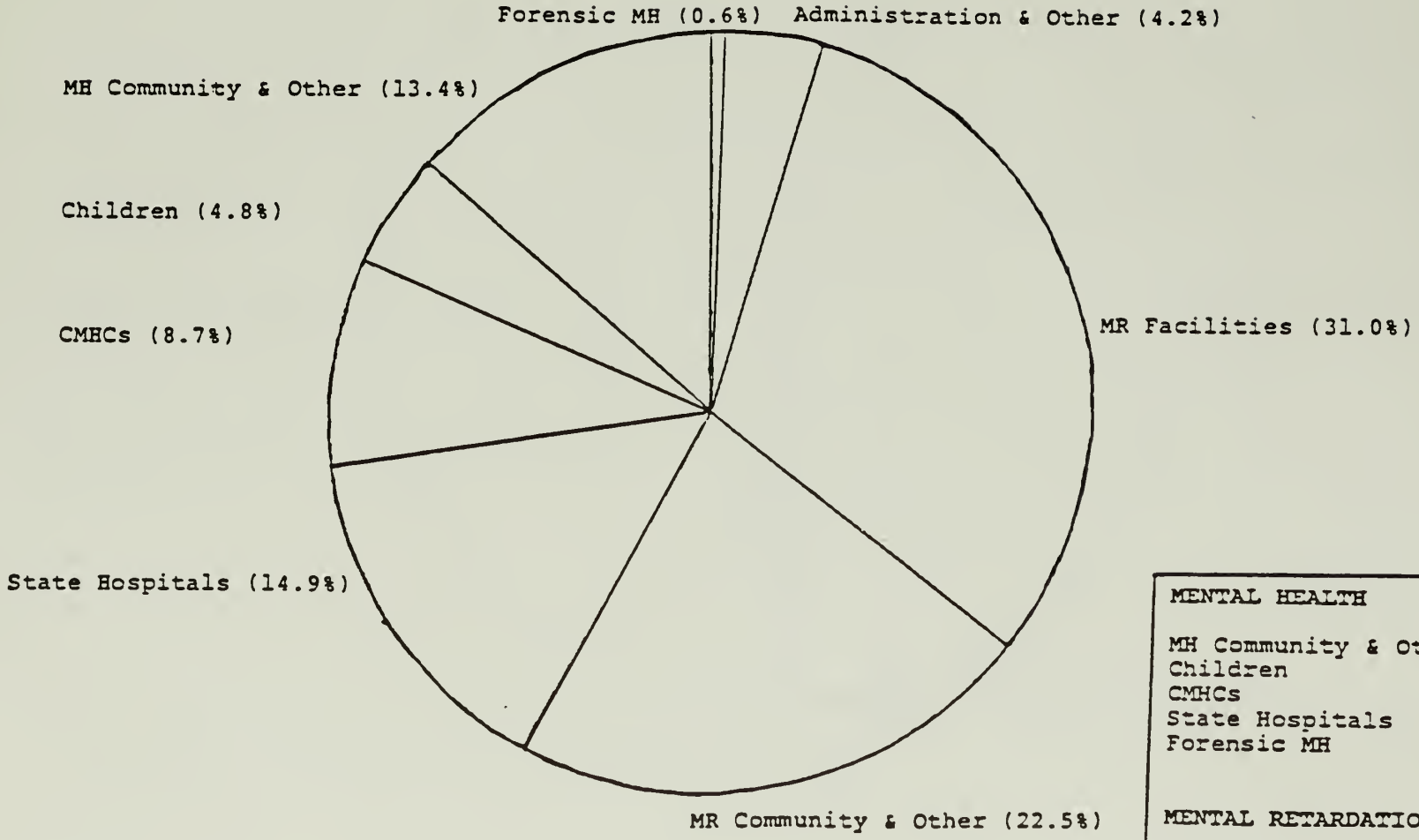
The new DMH must continue to develop a system of mental health services designed to provide treatment and follow-up for seriously mentally ill adults and children. This must include a focus on the needs of the homeless, on the needs of low-incidence populations, and on the needs of children who show signs of serious emotional disturbance. As with the DMR, the DMH must also continue to work on the development of standards and monitoring systems to ensure service quality and accountability.

The structural reorganization of the Department of Mental Health cannot achieve all of these goals. However, the plans for a new Department of Mental Retardation and a new Department of Mental Health are aimed at creating the management and service delivery structures necessary to enable these agencies to work effectively toward improved services.

TABLE 1-1

FUNDING DISTRIBUTED BY SERVICE CATEGORY

(FY' 87)



MENTAL HEALTH	
MH Community & Other	13.4%
Children	4.8%
CMHCs	8.7%
State Hospitals	14.9%
Forensic MH	0.6%
	42.4%
MENTAL RETARDATION	
MR Community & Other	22.5%
MR Facilities	31.0%
	53.5%
ADMINISTRATION & Other	
	4.2%

TABLE 1-2

DMH STAFF BY SERVICE CATEGORY

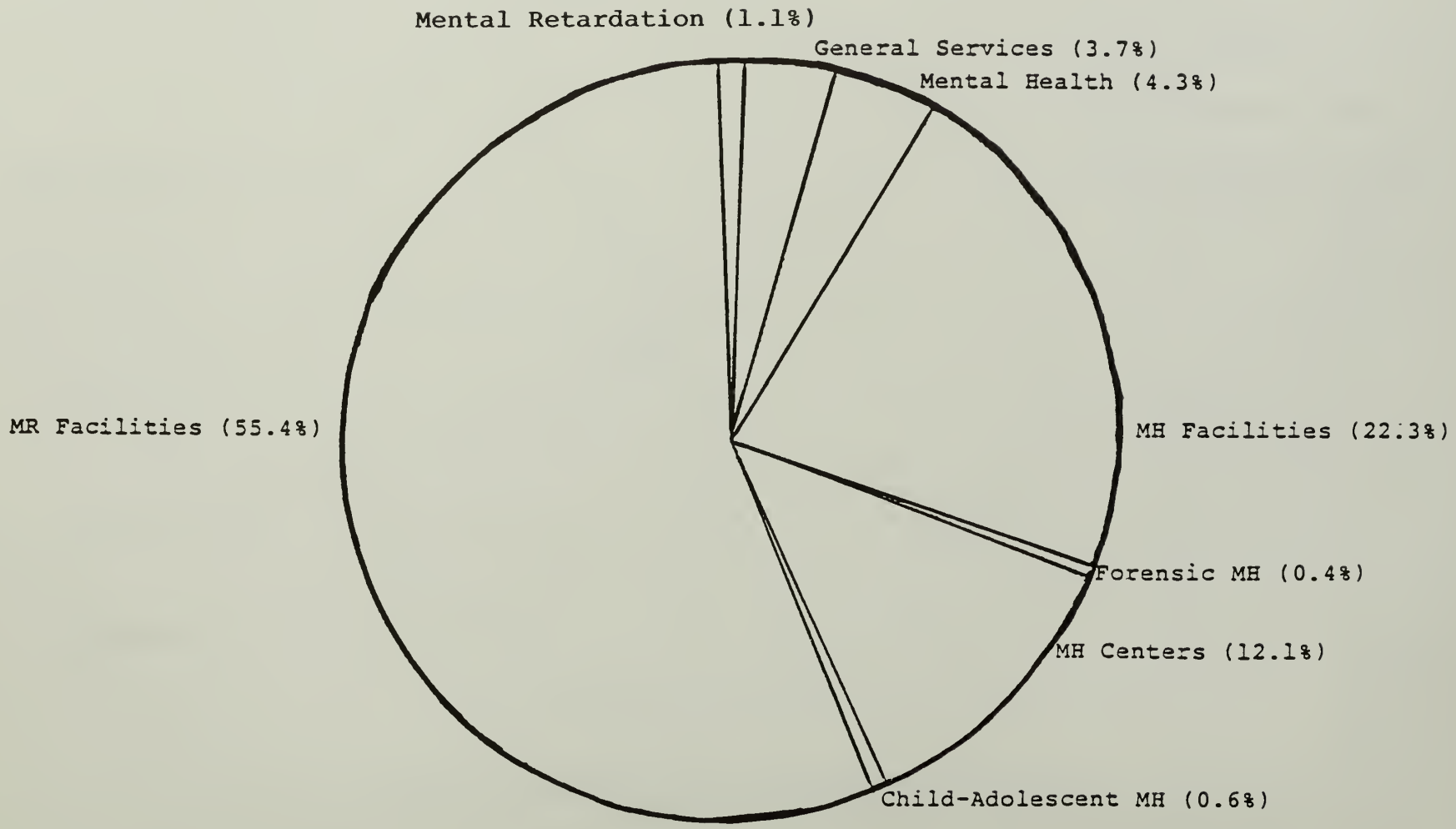


TABLE 1-3

CLIENTS OF THE DEPARTMENT

FISCAL YEAR 1986

MENTAL HEALTH SERVICES	
~ Inpatient Services	
State Hospitals	5,054
Community Mental Health Centers	3,113
~ Residential Services	1,169
~ Day Services	5,478
~ Day & Residential Services	1,590
~ Case Management	9,493
~ Outpatient & Clinic Services	100,000+
CHILD-ADOLESCENT SERVICES	
~ Inpatient Services (ages 1-21)	
State Hospitals (including statewide facilities)	760
Community Mental Health Centers	370
~ Residential Services	332
~ Day Services	1,272
~ Day & Residential Services	218
~ Case Management	4,108
MENTAL RETARDATION SERVICES	
~ State Schools/Regional Centers	3,463
~ Residential Services	1,013
~ Day Services	2,518
~ Day & Residential Services	3,258
~ Case Management	3,049
~ Service Coordination	10,587
~ Turning 22	227
~ Transportation	7,400

CHAPTER TWO

THE NEW DEPARTMENT OF MENTAL RETARDATION

The mandate of the Department of Mental Retardation is to take cognizance of all matters affecting the welfare of the mentally retarded citizens of the Commonwealth. This includes supervision and control of all public facilities for mentally retarded persons. The department will also exercise general supervision over private facilities providing services for mentally retarded persons.

The overriding mission of the new department is to develop, manage, monitor, and coordinate a system of responsive, high quality, and cost effective services. It is also the mission of DMR to target service resources on an equitable basis to those most in need, and to provide such services in safe and healthful environments designed to assist mentally retarded persons to attain the highest possible functioning and participation in society.

Mentally retarded persons have varying levels of impairment, perform at different functional levels, exhibit a wide range of abilities and behavior's, and can be faced with a number of complex medical, physical, and emotional problems. This requires that services respond to many individual differences. The new DMR is purposefully designed to support an individualized client service system while at the same time ensuring effective service development and efficient and accountable management.

Organizing Principles

The design of the new Department of Mental Retardation rests on several organizing principles. Experience with individual client service development and management, with service needs of underserved and unserved clients, and with the still evolving "Turning 22" system guided the development of these organizing principles:

- Mentally retarded persons in all parts of the Commonwealth will receive services in a consistent and equitable manner. Local service managers will have sufficient flexibility to respond to varying needs and conditions, but clients will receive essentially equal services regardless of where they live.

- Access to new services will be based on priority of need for services. The service system will facilitate equity of access by allocating resources to meet specific client needs.

- Within the context of statewide consistency and equity of access, both the management of individual client services and the generation of plans for new services will be accomplished locally. Clients and their families will have access to a clearly identifiable single point of entry to the system. This single point of entry will be geographically accessible in familiar community settings.

- The emphasis on community based services designed to encourage and support personal growth and community participation will be maintained through the local client service system. That system will also facilitate access to other community resources, such as housing, transportation, and medical care for mentally retarded clients.

- The management support functions necessary to maintain an efficient and responsive service system will be standardized and simplified. Each administrative component should have discrete and clearly defined responsibilities, and no administrative or service management functions should be unnecessarily duplicated at multiple levels in the organization.

The organization effectively satisfying these organizing principles is a three-tiered structure. Local service centers will perform client intake, service planning, program monitoring, and community relations functions. Program development and management, as well as administrative functions, will be located in regional offices. Regional offices will manage a broad pool of service resources to ensure targeting of priority clients and eliminate geographic barriers to service access. The central office will establish overall program policies and standards, and will support regional and local client service efforts through planning, research, training, and administrative support.

Priority Clientele

The Department of Mental Retardation will focus on maintaining existing services as well as on addressing the outstanding needs of clients on waiting lists. Clients now receiving services include class members in both institutional and community settings, and community clients in community-based settings. Waiting lists consist of community clients and clients entering the adult mental retardation system through the Turning-22 transition process. There are presently a total of 1,996

unserved and underserved persons on waiting lists and 431 clients who will be turning 22 and requiring services.

Range of Services

The new department will continue the range of services which meets basic needs of mentally retarded citizens and will strive to provide opportunities for each person to reach his/her fullest developmental potential.

Residential services are designed according to the level of client functioning. Programs range from cooperative apartments with minimal staff support to 24-hour institutional care. Over the next two years, 131 residential programs will be added which will not only help to reduce the waiting list but will also broaden and strengthen the base of community residential options.

Day programs provide training, employment and habilitation services designed to promote maximum development and enhance clients' self-care, domestic, social, community and vocational skills. This service also needs continued expansion if currently unserved persons and young adults turning 22 are to be served.

Support services include respite care, transportation, family support, clinical resource teams, and service coordination. A primary objective of the new department will be to continue to develop the capacity to work collaboratively with and support families by providing useful assistance and incorporating families in service planning and decision-making.

One service now available because mental retardation services are combined with mental health services, but which will be less readily available to DMR standing alone, is emergency and crisis intervention (see Chapter 5). In the short run, that service will be provided as a result of interagency agreements between DMR and DMH. In the long run a separate emergency and crisis intervention capacity will be developed by DMR. It should be noted however, that there will always be the need for DMR/DMH cooperation for certain clients.

Services to mentally retarded children are currently provided through both the Children's Division and the Mental Retardation Division of the department. At present 146 mentally retarded children are funded through the children's Individual Service Fund account, and 40 children are funded in residential services which are cost-shared between the Division of Mental Retardation and DSS, DPH or school systems. Area offices currently count 791 children who are on MR waiting lists. The responsibility of local education authorities under Chapter 766 dominates provision of services to mentally retarded children and should continue to do so. However, it has become widely recognized that this population is an insufficiently served group. Current MR services are not oriented toward this younger population. The need is clear for

enhanced focus on children's issues and service provision (See chapter 5).

Respite services are provided by both the Division of Mental Retardation and the Department of Social Services. That respite services are vested in two agencies has resulted in service fragmentation, which in turn creates a situation that is both difficult and confusing for families. With the establishment of the new department, with the stated goal of better coordinated services for mentally retarded individuals, it is appropriate that the Commonwealth consider transferring responsibility for respite services to the Department of Mental Retardation.

Service System Development

Program development efforts will be directly linked to client needs and systems analysis. Client planning will be carried out at all levels of the system based on waiting list information and the outstanding needs identified through the individual service planning (ISP) process.

Quality Assurance will encompass the department's licensing, program monitoring and service coordination systems. Department programs will be licensed in accordance with standards set forth in the mental retardation regulations. These standards pertain to rights, client records, individual service plans, periodic review of clients' services, and physical facility standards. Program reviews are now required to occur every two years. Currently under development, a standardized quality assurance review process will be initiated. These reviews will include family members, professionals, advocates and clients.

In addition to these systems, the department will rework inter-agency agreements with agencies providing inpatient services for mentally retarded citizens. These agencies include the Department of Public Welfare, Massachusetts Rehabilitation Commission, Departments of Public Health, Education, Social Services, Mental Health, and the Office for Children.

Organizational Structure and Management

Designing a new Department of Mental Retardation offers an unparalleled opportunity to develop a management structure which truly facilitates client service in the community and in institutions. A three-tiered system offers the greatest opportunity for reinforcing the client service link. Direct client interactions are emphasized at the local level, management support and program development occurs at the regional level, and standard setting and accountability is ensured by the central level. The functions of each level are described in greater detail below.

Local Service Center

The local service center (LSC) responsibilities are summarized in Table 2-2. The LCS will perform all client-related functions and serve as the point of entry into the system. The primary function of an LSC will be to plan and broker services for clients. Service coordinators located in an LSC will be responsible for development of an individual service plan (ISP) for each client on their caseloads. The service coordinator is also responsible for monitoring the implementation of an ISP and assisting in the coordination of family involvement.

The LSC role is to understand and represent the needs of those persons receiving or in need of services. This knowledge is necessary for decisions regarding contract renewal, program development, and program planning. Because of the LSC's knowledge of individual clients and services, its function is to aggregate the information regarding service needs and current quality of services and to make recommendations regarding short term and long term program development activity. This information will be integrated with other LSCs within the region so that a regional response can be developed. The focus ensures that the regional office will have accurate, client-centered information.

LSC service coordinators report directly to a service coordinator supervisor who in turn receives clinical supervision and guidance from the Coordinator of Clinical Services. The supervisors will ensure that service coordination is professional, timely and responsive to the needs of clients and their families.

The proposed structure designates certain service coordinators within each local service center to work exclusively with mentally retarded children. The intent of the structure is to allow this service coordinator to focus on the specific needs of mentally retarded children and their families. Additionally, a planning process will be initiated to review child-related functions currently performed by various other components of the system. This process will involve other state agencies and will result in interagency agreements designed to clarify roles and responsibilities regarding this population. As appropriate, specialized services needed for mentally retarded children will be identified and integrated into program development initiatives and priorities (see Chapter Five).

The Director of a local service center reports to a regional director and is considered part of the regional management team. The LSC director is accountable for the service coordination systems, as well as a local client needs assessment. The director is also responsible for the monitoring of all contracted programs in the area. Program siting, interagency relationships and community relations are also managed by the LSC director.

It is also proposed that three kinds of services be geographically targeted to each local service center:

- emergency services
- crisis intervention
- family support

These services will be managed at the regional level. However, because of the need for responsiveness and proximity, it is proposed that they be geographically targeted. The local service center will coordinate and utilize these services directly.

The Region

The regional office, which is shown in Table 2-3, is proposed as the primary field management point. Within it, management of the local service centers and of planning, program development and fiscal management will be performed. Central office managed functions of licensing, and quality assurance, investigation, and human rights will also operate from the region. The regional office will operate a clinical resource team to focus on special populations, particularly ED/MR persons and other low incidence groups.

The mental retardation facilities are not included in the region's management purview, but will report to central office. This approach has been taken for a number of reasons. First, the scope of the agenda in both the community and facility systems is extensive. Merging both responsibilities will prove overwhelming to the new regional management structure, possibly jeopardizing the opportunity to achieve needed gains and improvements. The tasks currently being undertaken by the facilities in personnel reassignment require interdependence and coordination among the facilities. Finally, it is critically important to assure that the gains made under the Federal Court Consent Decrees are solidified and that remaining obligations are fulfilled.

This is not to suggest that the facilities should remain apart from the community service system. As has been articulated in the department's Long Range Planning Task Force Report and recognized throughout the system, the facilities will transition to a new role as regional centers and become fully involved in the service system. State school resources will become more visible and accessible. Providing clinical expertise and integrating these resources into a network of emergency services is essential. Each facility will be assigned geographically to a region for operational purposes.

Central Office

Key responsibilities of the central office are institutional management, system accountability, resource management, equity of resource distribution, and quality of services. It is the a goal of the new department to assure that every client whether from the Berkshires or from Boston has access to a system that operates with a single set of standards and offers the same opportunity for services. To do so will require that the central office develop management systems. Proper management systems also will promote accountability throughout the system and will enable the department to present information to the Executive and Legislative branches in a manner that is responsive, and that effectively advocates for the mentally retarded citizens of the Commonwealth. Finally, the central level will assure the development and operation of standards and mechanisms for investigations, client rights, quality assurance and licensing that promotes and ensures high quality services.

The organization of the Central Office (Shown in Table 2-4) encompasses core functions of the agency. Clear field management lines are established to oversee system operations through Assistant Commissioner's for Community Services and Facility Operations. Financial management, budgeting, fiscal operations and physical plant management are organized under an Assistant Commissioner for Management Services. System-wide policy development and planning will be the responsibility of an assistant commissioner.

Investigations, Human Rights, Quality Assurance, and Affirmative Action/EEO functions will be placed in prominent positions by having each report to the commissioner or deputy commissioner of the agency. Each of these functions will be managed and directed by central office but will be carried out through the placement of staff in regional offices and state schools. These staff will operate in the context of those locations with regard to the geographic area to be served but will report to central office. The protection and promotion of the human rights of all clients will be a prominent concern throughout the entire system. The human rights function will work collaboratively with, direct, and provide assistance to human rights staff stationed throughout the organization. The Chief of Investigations will be the primary liaison and contact with the newly created Disabled Persons Protection Commission.

Citizen Participation

The new Department of Mental Retardation encourages citizen input in its activities. Formal citizen participation is planned at each departmental level to advise on client needs, program effectiveness and related issues which impact service delivery. Specific citizen advisory structures are proposed as follows:

- The Statewide Advisory Council (SAC) will be composed of 15 citizens appointed by the Secretary of Human Services. At a minimum, selection of council members should reflect representation of each region. It is recommended that each regional Advisory Committee have a representative to the SAC. Other members will be professionals and advocates in the mental retardation field, clients and family members;

- Regional Advisory Committees will be created to advise on regional services and needs. They will include at a minimum, two representatives from each Local Advisory Committee appointed by the DMR Commissioner;

- Local Advisory Committees will serve each of the local geographic areas. They will advise the local service center directors on matters relating to local needs and services.

In addition to these formal citizen mechanisms, ad hoc professional advisory committees will be sought for their expertise and input into DMR activities. The department will develop other structures to include consumers, advocates and family members in the planning and monitoring of services.

The department will also encourage the development of citizen advisory mechanisms through a program of leadership development, public information, recruitment of citizen volunteers and other activities geared to bring a sense of cohesion and mission to citizen boards.

In addition to these vehicles, the department will continue to rely on Human Rights Committees to provide perspective and judgment on client protections and treatments.

TABLE 2-1

SUMMARY OF OPERATIONAL FUNCTIONS
DEPARTMENT OF MENTAL RETARDATION

LOCAL	REGIONAL	CENTRAL
Intake, eligibility determination	Eligibility-monitoring & ensure standards	Develop and monitor statewide standards
Information and referral (I&R)	N/A	Develop and monitor statewide standards
Service Coordination/Case Management	N/A	Develop and monitor statewide standards
Client needs assessment and tracking	Client needs tracking • Regional Prioritization	Client needs tracking • Waiting list reviewed and resources allocated
Program monitoring • Implementation of ISPs by service coordinator • Liaison to region and follow-up	Program monitoring • Licensing-regionally located supervision by central office • Quality Assurance-implement policy and procedures	Program monitoring • Licensing-direct supervision of regional staff. Ensure implementation of regulations. • Quality assurance-establish standards, policy and procedures
Transportation requests	Transportation management	Transportation monitoring, planning and fiscal management
Program development • Generate client need information • Implementation	Program development • Regional need and resource assess. • Planning and coordination • Implementation and monitoring	Program development • Establish program development process and standards • Allocation of resources

TABLE 2-1

SUMMARY OF OPERATIONAL FUNCTIONS
DEPARTMENT OF MENTAL RETARDATION

LOCAL	REGIONAL	CENTRAL
Purchase of Services • Generate client need information • Identify client & program needs • Identify needed program elements • Advise on vendor selection/ performance • Implement and monitor contract specifications • Review vouchers to verify client service delivered. • Monitor utilization	Purchase of Services • Assess needs and resources • Determine program configuration by • Type and program • Implement RFP process and vendor selection • Monitor and coordinate utilization	Purchase of Services • Allocate resources • Oversee fiscal utilization • Maximize resources
Program siting/housing	Housing needs assessment/program siting	Chapter 689 liaiason to EOCD
Interagency relationships • Schools/LEA's • Local/state agencies	Interagency relationships and coordination • Regional/state agencies	Interagency agreements and policy development
Training • Identify needs	Training • Staff development training coordination-develop and implement regional plan	Training • Develop statewide training plan
Community acceptance • Implement with individual cities and towns • Address specific issues	Community Acceptance • Technical assistance • Oversight of community acceptance process	Community Acceptance • Establish policy and procedures

TABLE 2-1

SUMMARY OF OPERATIONAL FUNCTIONS
DEPARTMENT OF MENTAL RETARDATION

LOCAL	REGIONAL	CENTRAL
N/A	Human Rights/Investigation ● Investigation supervision ● Seclusion and Restraint monitoring	Human Rights/Investigation ● Policy ● Direction and Monitoring of systems
N/A	Legal assistance to Department ● Guardianship/ substituted judgment	Legal-review and advise
Legislative Relations ● Contact and information to local Legislators	Legislative affairs education and information	Legislative Liaison
Budget Development ● Identify client specific needs	Budget Development ● Regional need	Budget Development ● Statewide need and strategies
Maintain service delivery system ● Supervise service combination and client functions ● manage client issues ● emergency services ● monitor service delivery/ ISP requirements	Maintain service delivery system ● Supervise local service center director	Maintain service delivery ● Policy ● Standard setting ● Management review ● Performance evaluation
N/A	Personnel/Payroll	Personnel/Payroll

TABLE 2-2

LOCAL SERVICE CENTER
DEPARTMENT OF MENTAL RETARDATION

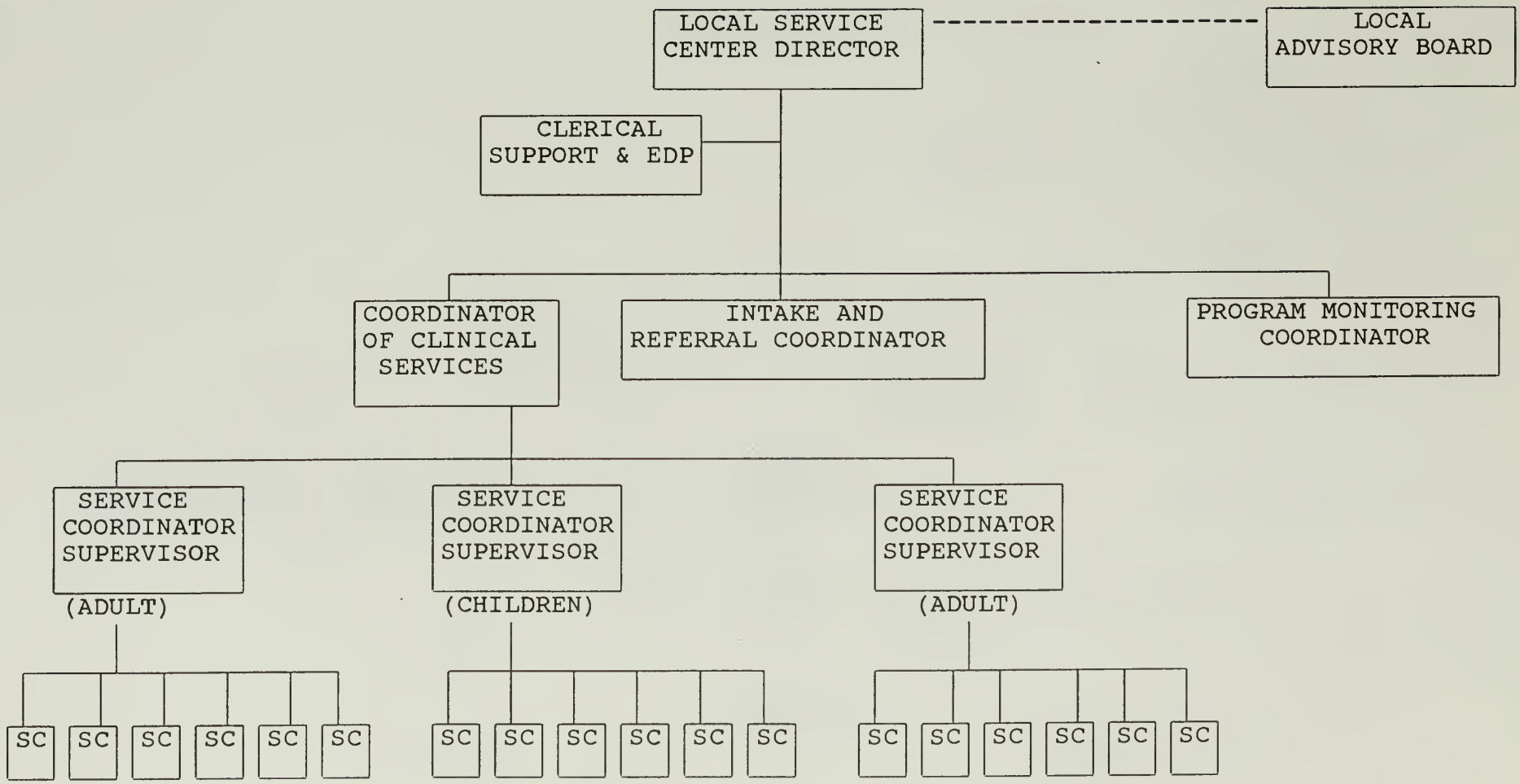


TABLE 2-3

REGIONAL OFFICE
DEPARTMENT OF MENTAL RETARDATION

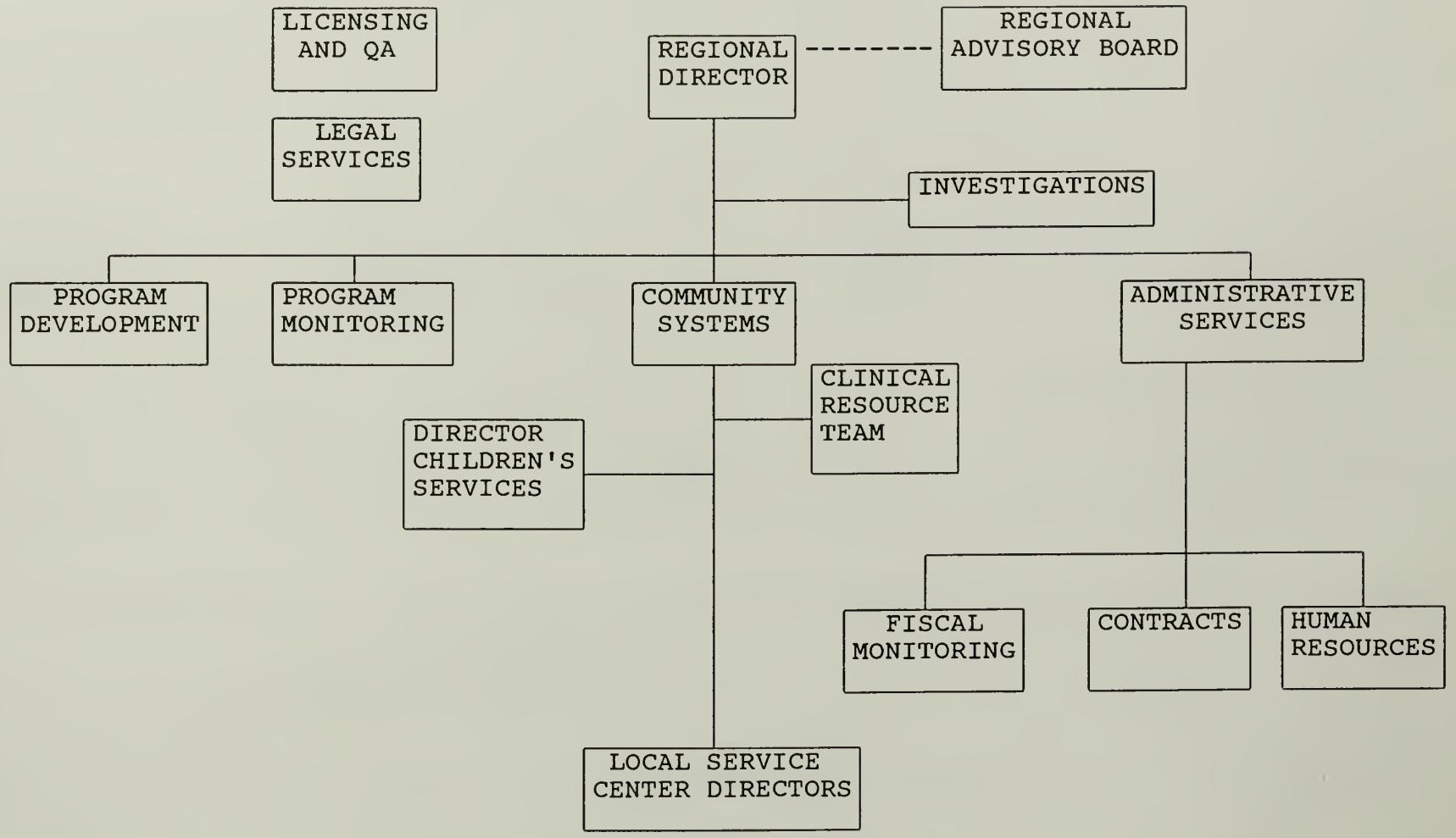
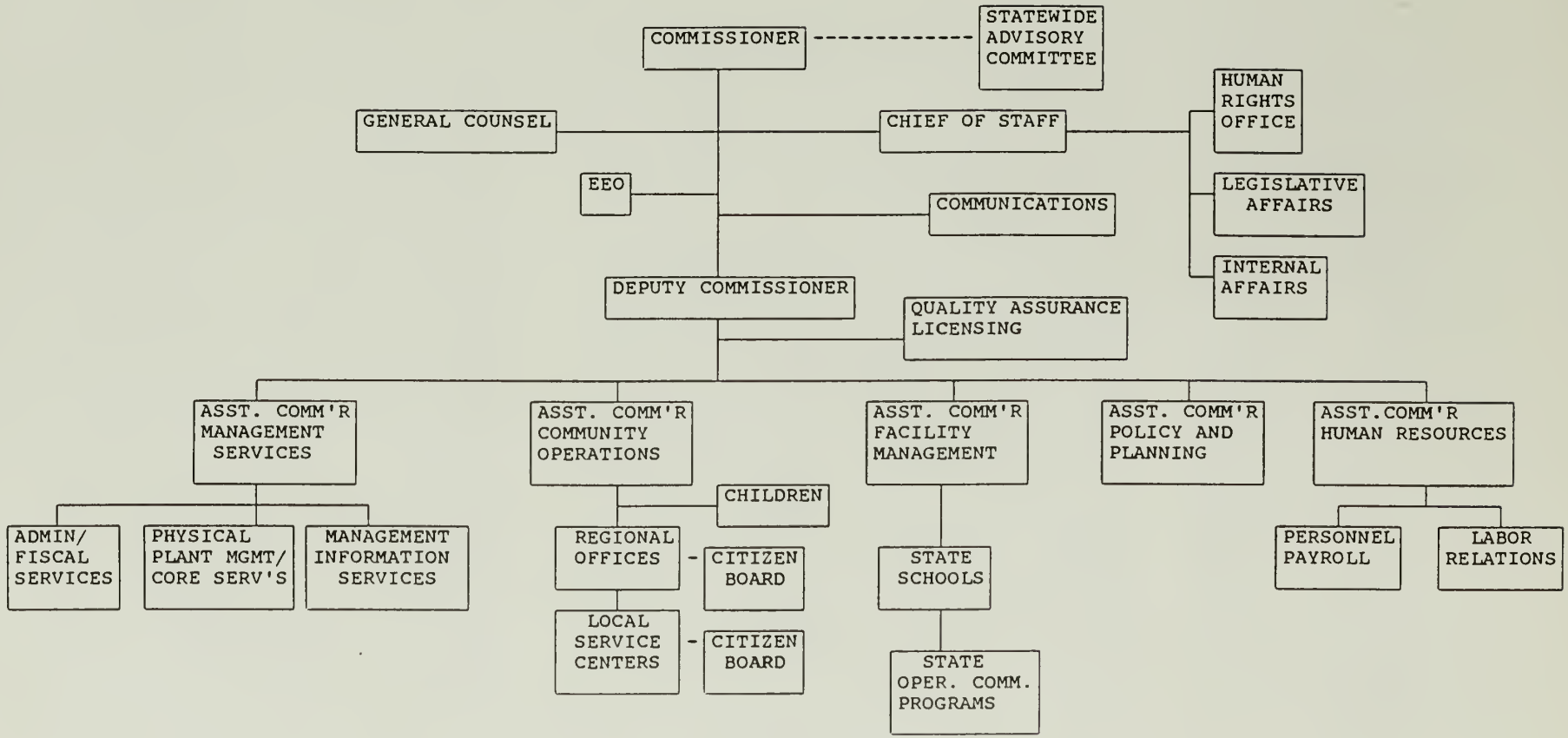


TABLE 2-4
DEPARTMENT OF MENTAL RETARDATION
CENTRAL OFFICE



CHAPTER THREE

THE NEW DEPARTMENT OF MENTAL HEALTH

The primary mission of the new Department of Mental Health under Chapter 599 "shall be to provide for services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness." This mission statement gives a focus to the department's activities that was not provided under the generalized mandate of the prior law. With this mission, the responsibilities of the new department include supervision and control of all public facilities for mentally ill persons and general supervision of all private facilities for such persons. The department must also develop and maintain a comprehensive, area-based system to provide community mental health services, including specialized services for children and adults.

The new DMH will continue the current emphasis on improving the quality of inpatient services and on developing an appropriate array of community mental health programs. The goal of the department is to have well qualified professionals deliver the best possible treatment to people who are mentally ill and to provide support services that mitigate the disabling consequences of the illness.

The vision of responding to mental illness as both a treatable illness and a potentially disabling condition was articulated in the Governor's Special Message. The ideal is a system where inpatient treatment is augmented by outpatient, rehabilitation, training, housing, community placement, and emergency service programs coordinated by a case manager. This system is designed to avoid the fragmentation which has sometimes characterized mental health services.

Organizational restructuring will not in itself, address the unmet service needs of the mentally ill or larger societal issues, such as homelessness and lack of housing opportunities. The department will continue to address these program considerations in other forums. The following plan focuses on the department's plan to restructure its management and organizational structure to implement the new mandate.

Organizing Principles

The foundation of the plan for the new Department of Mental Health is a series of organizing principles which are consistent with the agency mandate and adhered to by its staff. The principles call for:

1) Client Services which build on the strengths of individuals and their families; provide clinically appropriate care and treatment and are considerate of specialized needs;

2) Service system development which re-evaluates and re-distributes program and service allocations as needs change; and monitors and adapts successful program models from across the state and country;

3) A Management Structure which has a clearly defined set of responsibilities at each level of the organization and a single line of authority from the commissioner to the service delivery level; and provides clear expectations and performance evaluations of personnel and programs/services;

4) Citizen/consumer involvement which formalizes and promotes participation at all levels of the organization in the planning, development, delivery and evaluation of department services;

5) Collaboration with any other element of Government that can aid the department's mission.

Priority Clientele

The Department of Mental Health plays a number of roles within the mental health system of Massachusetts. Primarily, the department will be responsible for treatment and care of persons with serious or long-term mental illness. The department is moving to focus more of its attention on this population and will continue to do so.

In addition to its responsibility to persons with serious or long-term mental illness, DMH retains its commitment to the mental health of other citizens of Massachusetts. This responsibility will take many forms, but will generally be an advocacy and regulatory role, rather than a direct service responsibility. Following is a description of three distinct populations of persons with mental health related problems and the department's responsibility to each population.

Persons Who Are Seriously Or Long Term Mentally Ill

The primary target population of the DMH will be adults and young with diagnoses of serious mental illness, often of long

duration, who are unable to meet life support needs of shelter, food, clothing and self care or whose behavior presents a danger to themselves or others; and children or adolescents up to age 18 who are at risk of or are suffering from serious mental illness. These categories may include children and adolescents who are seriously emotionally disturbed, young adults with serious or long-term mental illness, and middle-aged or elderly persons who have been in and out of the system for years. These persons may be living independently or at home with family members, they may be in DMH facilities or community programs, they may be incarcerated, or they may be homeless.

Indicators of dysfunctionality in this population include: danger to self or others by reason of mental illness; inability to meet age appropriate life support needs of food, shelter, clothing, and health care; inability to cope with daily pressures inherent in community living; history of repeated psychiatric hospitalizations due to an acute exacerbation of a chronic condition; or history of mental health treatment characterized by poor or inconsistent compliance.

Children's services offered by the department will be targeted to those children and adolescents (up to age 18) who are at risk of or suffering from serious mental illness. Persons between the ages of 19 and 21 will be served either by children's services or by adult services depending upon their individual needs or in accordance with specific mandates.

The department's child-adolescent service system will provide age-appropriate services to mentally ill and seriously emotionally disturbed children and adolescents under the age of nineteen. As with the adult population, the department's major obligation to children and adolescents will be to provide a continuum of mental health services for those who cannot receive such services elsewhere. Highest priority will be given to those mentally ill and seriously disturbed children and adolescents who are:

- receiving or at risk of inpatient hospitalization;
- receiving residential or day/vocational services;
- referred for hospitalization, residential, or day/vocational services;
- referred to DMH from the Interdepartmental Team, or
- participating in the Psych Under 21 Medicaid Program.

Persons in the Community with Mental Health Impairments

In addition to its primary responsibility for persons with serious or long-term mental illness, the department has a secondary responsibility to those who have urgent mental health needs which may not lead to serious or long-term mental illness, but which require professional intervention.

Since most of the persons in this category will turn to the private mental health sector for help, the department's responsibility to this population will primarily be as system

advocate and regulator. As advocate, DMH supports efforts to make mental health services available at reasonable cost for persons who need mental health care. As system regulator, the department's licensing authority renders it responsible for assuring the quality of inpatient care in free standing mental health hospitals and psychiatric units in general hospitals that accept involuntary commitments.

Persons with Emotional/Behavioral/Functional Disturbance Who Are Not Mentally Ill

The department's third level of responsibility is to take a role in the care of those persons who exhibit symptoms of mental illness or emotional disturbances which are secondary to another condition. This may include persons with Huntington's disease, stroke-related brain damage, Alzheimer's disease, HIV-related dementia, mental retardation, head injury, or substance abuse problems. DMH will not be responsible for the primary care of persons whose primary diagnosis is not mental illness. However, because DMH has expertise in dealing with similar behavioral problems, in some cases the department may take responsibility for a secondary role in the treatment of these disorders. This role may include consultation and evaluation, behavior management suggestions, psychopharmacological work, etc. Interdepartmental agreements between DMH, DMR and other state, federal and private agencies will delineate agency responsibilities to persons in this population.

Range of Services

The primary target population of the new DMH is clearly defined. As described above, within that population there are a number of groups with a range of service needs. The services of the new DMH will respond to the broad range of needs of each of the sub-groups within the department's primary target population.

Under the new law, DMH must "develop and maintain, subject to appropriation and in accordance with its standards, a comprehensive area-based system to provide community mental health services, including specialized services for both children and adults." Specific services delineated in the statute include inpatient, outpatient, 24-hour emergency, partial hospitalization, and consultation and education services, as well as employment opportunities for patients. In addition, the department is directed to include, where applicable, inpatient diagnostic services; rehabilitative services; prevention, precare and aftercare services; and research programs including evaluation of effectiveness and efficiency of various area programs.

The department is committed to providing a comprehensive range of services within a balanced service system. This includes those services mentioned in the statute as well as those specified in the Governor's Special Message, including inpatient, housing

and residential services, forensic mental health, and community support services. A great deal of work has been done in recent years to develop this range of services across the state, and many variations of this service mix currently exist.

In addition to its client services, the Department of Mental Health will continue to sponsor mental health research. Three principal research components will be pursued. The first component involves basic bio-medical research into the causes and treatment of mental illness. The second component is policy-directed research to insure that policy and program development decisions are founded on careful study. Finally, evaluation research will be conducted to determine the effectiveness of client service delivery systems and to measure clients' responses to program treatment.

The department will also continue and expand upon program monitoring and evaluation efforts. These will include, at a minimum, licensing, quality assurance, and accreditation activities. Licensing is a process by which programs are judged to meet state standards of care, and quality assurance is an internal ongoing review of program quality. The quality assurance function is performed within each program using methods developed at central office. Through accreditation, state-operated programs are judged to meet national standards of quality, such as those established by the Joint Commission on Accreditation of Hospitals.

The department's range of client services, research efforts, and program evaluation activities will all be directed towards the department's primary mission, which will be the development of services and redeployment of resources to ensure that all priority clients have consistent and equitable access to an appropriate mix and range of treatment and services. The case management system, through its individual client needs assessment process and its client tracking function, will provide managers with information necessary to tailor services and programs to fit the needs of clients.

Development of Services

Case management work at the local level will provide information on the gaps in existing services where client needs are not met. This, in turn will provide the impetus for service development work at local and regional levels. The development and maintenance of services will occur within a cycle characterized by four phases, planning, implementing, monitoring, and evaluation. Services may be provided directly by state employees, as in the case of state-operated mental health centers, or they may be purchased from private.

The development cycle for new programs will be more systematic for some areas than it has been in the past. For

instance, standards developed at central office will specify how resources should be distributed throughout a local system to ensure balanced services. Regional managers will be responsible for resource allocation in their regions. Case management information will influence development of standards to determine exactly which clients will benefit most from a particular service.

In terms of specific activities, areas will propose program specifications. These specifications will be used by the region to create a standard RFP. Areas will then work closely with the regional office to select an appropriate vendor. In cases of low incidence populations with specialized needs, the regional office will monitor the needs of clients throughout the region and initiate program planning when appropriate.

Once a program is in operation, areas will be responsible for ongoing program monitoring, while regions will retain fiscal responsibility for program operations. Vouchers, for example, will be paid by the regional office, but monitored by the area office for utilization information. Both fiscal and program monitoring information will be available to persons responsible for program evaluation and planning. These interdependent management activities require effective information flow and constant vigilance to balance services to meet needs of priority clients.

Organization Structure and Management

The proposed organizational structure has three levels: central, regional, and area level offices. The structure reflects an emphasis on single point accountability; each position reports to a single supervisor and is responsible for unique functions. Proposed organization charts appear as Tables 3-1 and 3-2.

Central office will focus on hospital management, developing policy and regulatory standards, planning, prioritizing needs and advocating for resources. The commissioner will oversee all statutory responsibilities of the department. Offices of the General Counsel, Policy and Planning and Equal Employment Opportunity (EEO) will operate directly from the commissioner's office. Offices of Internal Affairs, Communications, Legislative Affairs, and Human Rights will operate through the Chief of Staff.

The Deputy Commissioner for Professional Services will provide professional direction for all clinical services operated by the department. This position will also direct central office licensing, quality assurance and accreditation functions, and oversee psychiatric residency and multi-disciplinary training programs. Licensers will work out of regional offices but receive professional direction from the deputy commissioner. Likewise, attorneys and human rights officers will serve at regional level

but receive direction directly from their counterparts in central office. This will preserve the independence of these functions. The Office of Management Services will oversee budgetary, human resources and management services of the department, including contracting, fiscal auditing and MIS.

The Deputy Commissioner for Operations will have direct authority for all services operated by the department in the community and in the department's facilities. This authority will be delegated to four offices with distinct responsibilities. These include Community Services, Hospital Management, Child-Adolescent Services and Forensic Mental Health.

The Office of Hospital Management will be responsible for administration of seven state psychiatric hospitals, Bridgewater Treatment Center, and Gaebler Children's Center. The Office will prioritize needs and develop program standards, policy, and resources for these facilities. Chief Operating Officers will be responsible for program planning, standards control and patient care. Planning for expansion of inpatient services will include consideration of low incidence and special needs inpatient services, as well as contractual arrangements with private vendors (i.e. community hospitals, psychiatric hospitals, chronic care, and skilled nursing facilities).

Hospital-based legal, quality assurance and human rights staff will work on a daily basis with the Chief Operating Officers and other hospital staff but will receive professional direction from appropriate central office divisions. Chief Operating Officers will be responsible for maintaining linkages with regional field operations managers. These linkages will include detailed working agreements with stipulated policies and procedures regarding hospital admission and discharge, case management of clients during hospitalization, and related areas of hospital-community program interface.

Child-Adolescent Services will be responsible for the operation of all statewide adolescent programs and for coordinating with regions and areas on behalf of child and adolescent clients. Child-Adolescent Services will provide program direction and technical support to service coordinators at the local and regional levels. Forensic Mental Health will be responsible for operation of all forensic mental health services in the community and in the department's facilities. In addition, like Child-Adolescent Services, the office of Forensic Mental Health will coordinate with regions, area offices and facilities on behalf of forensic clients and provide policy direction and technical support to the field.

The Offices of Child-Adolescent Services and Forensic Mental Health will not supervise community and facility programs, except for those programs noted above. However, central direction and coordination of these programs are crucial in order to develop and expand high quality specialty services and maintain program

standards and accountability. Therefore, these program offices will have authority over community funds allocated to their respective client populations. This fiscal authority provides accountability to the Offices of Child-Adolescent Services and Forensic Mental Health without abandoning the commitment to single lines of supervisory authority.

Community Services will have direct authority over all community programs, with the exception of forensic mental health services and statewide children's programs. The office of Community Services will oversee regional offices, which in turn will oversee area offices. Program direction and technical support on adult services issues will also be provided by this office.

The regional office level will insure that standardized services exist in all areas through planning, monitoring, licensing, and quality assurance functions. Program planning for low incidence and special needs populations will occur at the regional level. In addition, functions currently performed by the Service Bureaus, such as contracts management, will occur at the regional level.

In keeping with the emphasis on single point accountability, the Field Operations Manager will direct regional operations and will have line authority for programs and fiscal administration. All human resource activities, including recruitment, development and training, labor relations, and payroll will occur at the regional office. Finally, Field Operations Managers will develop and maintain linkages with the new DMR regional offices, especially concerning dual-diagnosed clients, and with Chief Operating Officers at state hospitals.

The area office level will be the principal locus of service delivery. Primary area responsibilities will include service delivery, case management, ISP development, client service coordination, community relations, and program monitoring. As described in the Development of Services section above, area staff will be responsible for formulating program specifications, working closely with the regional office around selection of new vendors, and for programmatic monitoring of vouchers and contract compliance. Those areas that contain a state-operated CMHC with an inpatient service will have the additional responsibilities of facility operation and inpatient service delivery.

The population size of Metro-Boston, coupled with its six state-operated CMHCs with inpatient capacity, requires a modification of the organizational structure proposed for the remainder of the state. The Metro-Boston regional office will combine functions of area and regional offices as described above. The Metro-Boston Director will report directly to the Deputy Commissioner for Operations and will supervise superintendents who will oversee the operation of the CMHCs. As with other areas

across the state, case management services will be offered at multiple sites throughout the area.

Citizen Participation

The Department of Mental Health historically has been committed to involvement of citizens in departmental activities. In the new DMH, citizen participation will include statutory citizen advisory mechanisms as well as other formal and informal structures to be encouraged throughout the organization. Specifically, the DMH will include the following formal citizen advisory structures:

- The Statewide Advisory Council will be comprised of 15 citizens appointed by the Secretary of Human Services. At a minimum, selection of those to be appointed should be arranged such that each region is represented by at least one member. Other members will be professionals and advocates of the mental health service system, clients, and their family members. This Council will continue to advise the commissioner in all matters pertaining to the mission and services of the department.

- Regional Advisory Boards will be added to the system of formal citizen participation. These boards will be appointed by the commissioner and will be comprised of representatives nominated by each Area Board within the region and other interested citizens.

- Area Boards will continue to serve each Area. These Boards will be comprised of 15 local citizens appointed by the commissioner and will be responsible for advising Area Directors on matters relating to area needs and services. In order to promote continuity of citizen participation, current Area Boards will continue to function throughout the transition period as citizen committees. These committees may recommend representatives to the commissioner to be appointed to serve on the formal Area Board.

- State Hospital Trustees will be appointed by the Governor to serve in an advisory capacity at each institution.

Current ad hoc professional advisory committees working with the department on various initiatives will be retained and further development of such committees will be encouraged. The department will also explore other mechanisms and structures which can be developed to involve advocates, consumers, family members of the mentally ill, and other interested citizens in the planning and monitoring of mental health Services.

Finally, in order to encourage the development of citizen advisory mechanisms, the department will encourage efforts of the State Advisory Council to develop a program of leadership

development, public information, recruitment of citizen volunteers and other citizen participation activities. This may include the development of mechanisms to increase communication between Area Boards and sponsorship of activities which bring a sense of mission and cohesiveness to Area Boards.

TABLE 3-1
DEPARTMENT OF MENTAL HEALTH
TABLE OF ORGANIZATION

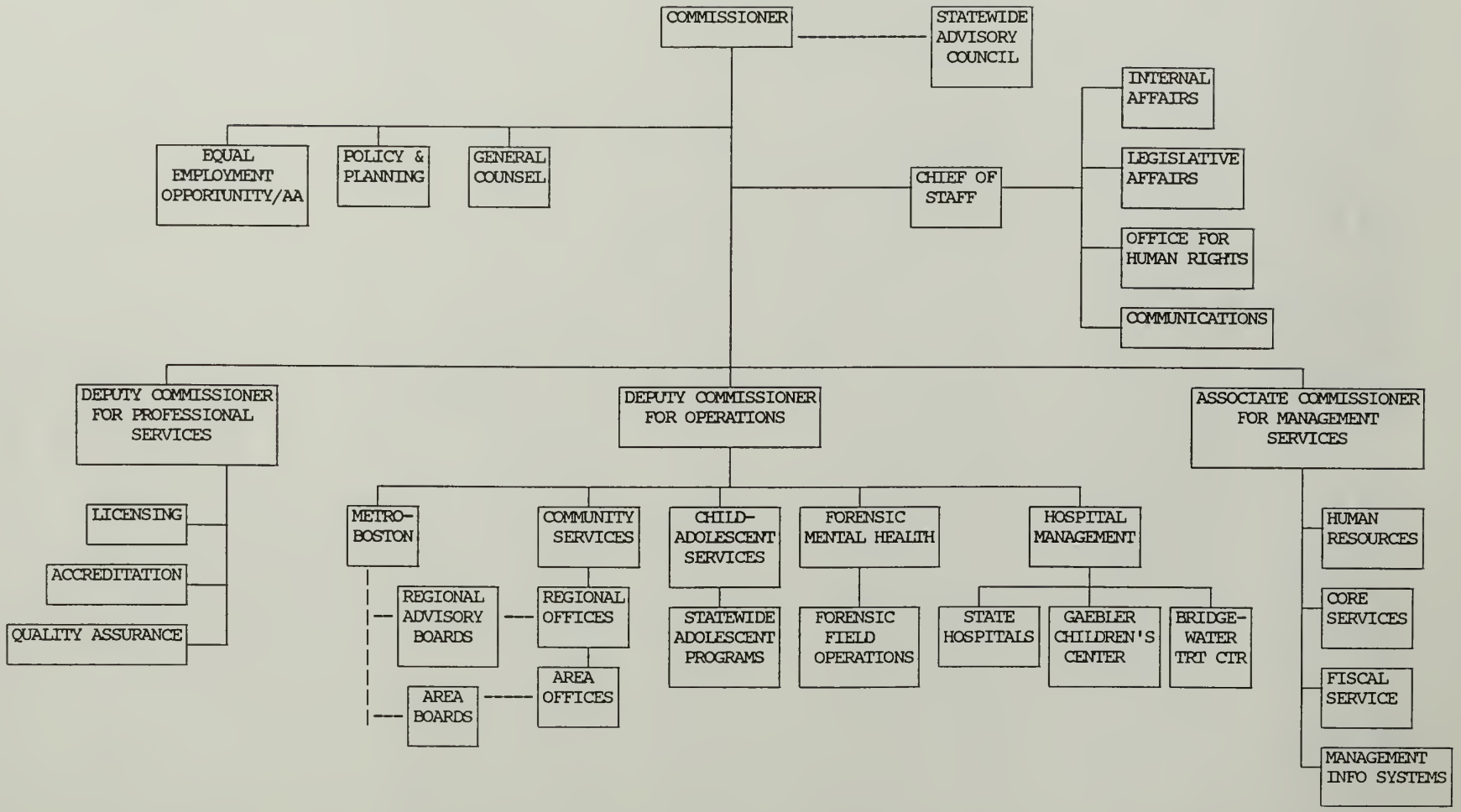
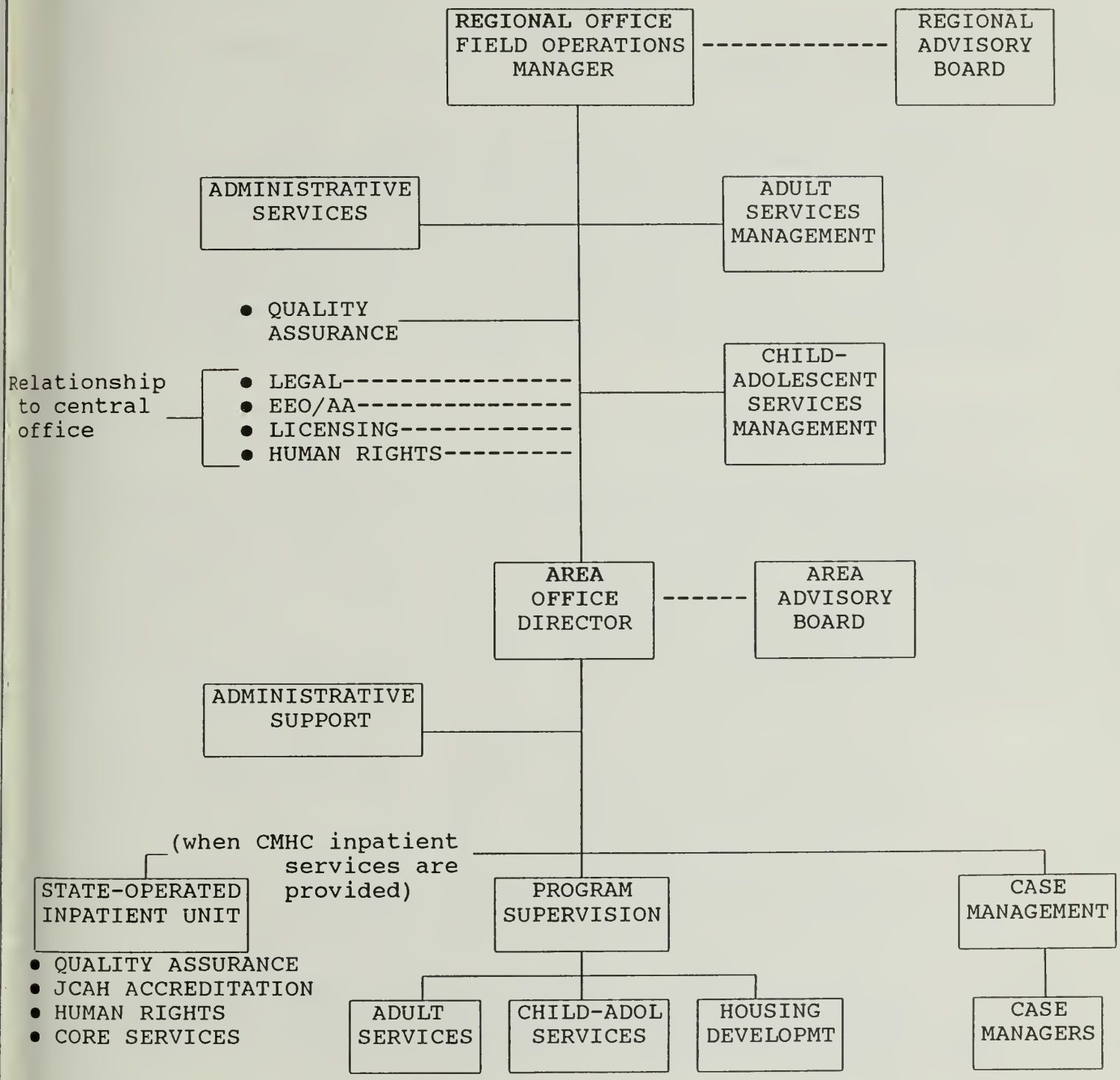


TABLE 3-2
DEPARTMENT OF MENTAL HEALTH
REGIONAL & AREA ORGANIZATION



Boxes denote functions, and not necessarily individuals.

CHAPTER FOUR

SERVICES FOR DUAL-DIAGNOSED AND SPECIAL NEEDS CLIENTS

The law creating the Department of Mental Retardation gives the new department primary responsibility for mentally retarded citizens regardless of whether such persons are also mentally ill. This mandate raises clinical service issues for clients who are both mentally retarded and mentally ill and who require the services and expertise of both the mental health and mental retardation agencies. This chapter describes those clients and the current service system. It also contains recommendations for development of mental health and mental retardation services and joint DMH/DMR programs.

Description of the Clients

The dual-diagnosed population is not homogeneous; varying levels of security, intensity, and a range of program components will be necessary to address their diverse service needs. Below are general descriptions of this client population, listed in order of greater to lesser prevalence in the DMH service system:

- mentally retarded individuals with a major mental illness who are experiencing a serious psychotic episode;

- mentally retarded individuals in acute crisis or distress (e.g., borderline personality disorder, depression, generalized anxiety disorder) experiencing some life or situational distress such as loss of family member, staff person leaves, etc.

- mentally retarded individuals with organic brain syndrome disorders, who present major and often sudden changes and disruptions or deterioration in their functioning, probably due to neurologic damage;

- mentally retarded individuals with disorders of impulse control who are undersocialized and sporadically commit violent, aggressive acts, often towards family members and those who assault or rape, or set fires;

At present, there are between 250 and 275 mentally retarded individuals in state hospitals, only some of whom have a secondary

diagnosis of mental illness. Because many community MR clients have been unserved, and further, because those dual-diagnosed who have been served have not received separate, specialized services, it is not currently possible to project total numbers of dual-diagnosed individuals. It is also not possible to predict the percentage of those requiring inpatient, outpatient, and specialized residential services.

Discussion of the dual-diagnosed population has tended to focus on those clients with an MR diagnosis and psychiatric service needs. It should also be noted, however, that there are primarily mentally ill DMH clients with cognitive deficits who could benefit from programs, especially vocational and residential, designed for the mildly retarded. Current mental retardation diagnosis requirements place major constraints on client access to the mental retardation service system. These criteria are highly exclusionary, and often act as a barrier to client participation in appropriate programs. Though a specific recommendation regarding assignment of responsibility for improving access and/or availability of these services is not made here, there is consensus that more attention must be paid to this underserved population.

The Dual-Diagnosed Client in the Current System

Basic differences in orientation between the current Mental Health and Mental Retardation Divisions affect care and treatment of the dual-diagnosed client. Mental retardation services are primarily habilitative in that they focus on assisting clients adapt to community living via a system of social supports, educational, vocational, and behavioral training, and skills development. Mental health services have a predominantly clinical focus, and center on the diagnosis and treatment of underlying pathology. A melding of the two orientations into a third approach is necessary in order to provide the dual-diagnosed population with appropriate care and treatment.

The parameters of the mental retardation system have been narrowly drawn, due in large part to the need to upgrade services for clients of the state schools pursuant to requirements of the federal consent decrees. An indirect consequence has been the limited availability of and access to the full range of services needed by community MR clients, including emergency treatment and respite in a secure setting. The mental health system and the state hospitals, in particular, have not had constraints on admissions. The combination of the inadequate supply of necessary MR services, and the open door policy of the mental health inpatient system has resulted in inappropriate and prolonged psychiatric hospitalizations for many dual-diagnosed clients for whom alternative or specialized facilities are not available.

The problems that dual-diagnosed adults now face in getting appropriate services are seriously exacerbated for children and

adolescents. Many state and local agencies including DMH, DSS, DPH, DOE, and the Local Educational Authorities (LEA), now share responsibility for serving these children. The haphazard distribution of this responsibility has inadvertently encouraged interagency buck-passing, which in turn has created substantial program gaps.

Basic Prescription for the New System

The dual-diagnosed population, then, is not well served by the existing system. Unless substantial corrective measures are taken, the problems these clients face in receiving appropriate services will only be worsened by the impending split of the department. These steps must include:

- identifying specific clinical service needs of this population, and defining and requiring a reasonable timeframe for developing these services;
- assigning agency responsibility for developing these services; and
- assigning agency responsibility for continuous case management.

A reorganization of existing administrative and financial resources will not sufficiently address the problem of inadequate access, as the programs needed do not now exist. If this population is to be appropriately served, new clinical and service costs will be involved.

As separate, independent agencies, both DMH and DMR must develop a fuller array of clinical and rehabilitative services. Further, in order to provide appropriate care and treatment to the dual-diagnosed population, it will be necessary not only to broaden each agency's knowledge and service base, but to formulate a whole new interdisciplinary approach.

The new system must be flexible enough to allow for clinical treatment decisions based on immediate service needs, rather than solely on diagnosis. While separate and distinct programs will be developed by each agency, dual-diagnosed and other special needs clients will require access to both agencies' services. This will be achieved via a system of interdisciplinary clinical teams located at the service delivery (service center or regional) and program planning and policy (central) levels, and by formalizing protocols for interagency, collaborative clinical decision-making. With the establishment of an independent MR agency, it is critical that DMR develop clinical and facility capacity, and that there be a corresponding clarification and redefinition of DMH's clinical services designed for the mentally retarded population.

Department of Mental Retardation

The Department of Mental Retardation will have ongoing case management responsibilities for client groups described in this report. The majority of program development will also be the responsibility of the DMR.

Consistent definitions of MR eligibility, with specific attention to eligibility for children and adolescents must be developed. Also, existing exclusionary criteria that preclude appropriate MR program participation by DMH clients with functional mental retardation should be re-examined.

Emergency and Residential Services

As stated previously, the mental health system has historically filled in the mental retardation residential and secure treatment service gaps. This relationship must change. It will be necessary for DMR to develop specialized emergency care and respite capacity so that DMR clients are not hospitalized without appropriate services, nor stuck in excessively costly and restrictive acute settings awaiting more suitable placement. At least one such program should be developed per region.

To assure that the system can respond in a timely and appropriate manner to client need, DMR must also develop adequate residential capacity to serve dual-diagnosed populations. A variety of program prototypes are needed, including post-acute transitional, and intermediate stay and long-term settings.

Forensic Services

As DMR will interface with the court system on a much more sporadic and limited basis than DMH, it will not be necessary for DMR to duplicate DMH forensic services. Rather, access will be through DMH forensic services, with DMR maintaining an ongoing case management function. DMR must occasionally make specialized clinical resources available for DMH for this purpose. Following is a brief description of the proposed organizational model:

- DMR will provide at least one resource team per region whose membership will include at least one Ph.D. level psychologist. The number of teams should be based upon need and population. The team will be employees of DMR rather than consultants, as intimate knowledge of system resources and problems will be crucial to the team's effectiveness.

- DMH forensic or emergency services personnel who have need of the team's services will contact the team directly. The team psychologist should be available by beeper seven days per week.

- If assessments or testing are necessary for disposition, etc., the team will provide them directly, or secure services of a competent, appropriately licensed and designated professional.

- If specialized referral or consultation services are needed which are not available as part of the regular process, the team will have the capacity to offer them.

- If short-term or crisis therapy is needed - behavioral, etc. - the team's psychologist will provide it.

- DMR will meet with DMH personnel on a regular basis - weekly/monthly, etc. - in order to maintain working relations and information flow. DMH will be responsible for orientation of DMR teams to courts, corrections, etc.

In addition, there is currently an agreement between DMH Child/Adolescent Division and the District Courts which systematizes access to child/adolescent expertise by District Court Judges. The agreement also identifies a "Court Liaison" from each area office to provide access and input to these judges. DMR must develop such capacity for providing specialized back-up to DMH for the dual-diagnosed child/adolescent client who is court-involved.

Children's Services

Over the course of a number of years, DMR must assume responsibility for dual-diagnosed children, as the new statute requires. This effort will require understanding between the departments:

- To begin to establish fiscal responsibility for serving this population, all related existing funding must be transferred to DMR;

- The specialty services that are now provided by DMH to dual-diagnosed children will be continued under interagency agreements but not duplicated;

- DMR will develop a five-year transition plan for the development of the capacity to serve dual-diagnosed children. The initial phase will consist of case management and referral services, followed by expanded service delivery. This transition plan will be coordinated by EOHS and communicated to DSS, DOE, etc., to assure a shared set of expectations of DMR's actual service capacity.

It is essential that the system serving dual-diagnosed children be staffed by clinicians who specialize in the care and treatment of the dual-diagnosed population. In addition, all children and adolescents must have assessments and programming delivered by clinicians trained in the unique developmental issues of childhood and adolescence. The development of a cadre of specially trained clinicians will be the joint responsibility of DMH and DMR (See "Joint Programs" section of this chapter).

There are some interagency issues unique to children's services. They are:

- To insure the integration of services to dual-diagnosed children and adolescents, full integration of DMR into the EOHS system will be necessary. This must include development of a mechanism to involve DMR in the EOHS interagency team system.

- An Interagency Agreement between DMR and OFC, paralleling the current DMH-OFC Interagency Agreement will be developed.

- The DMR local service system must have the capability to interact with other related area-based systems such as DSS and the LEAs.

Child/Adolescent Case Management Services

The transitional plan for joint DMH/DMR child/adolescent case management services is:

- A full-time Child/Adolescent staff person should be assigned at the central level of DMR. This position is needed to provide leadership for services to MR and dual-diagnosed children and adolescents;

- Persons responsible for services to children and adolescents should be identified at the DMR regional level. Such contacts are necessary to integrate DMR into the EOHS/OFC Interagency Team system which operates on a three-tiered structure (area, regional, central). Experience suggests that strong relationships at the central and regional levels among EOHS agencies can improve services to low-incidence populations and avoid inappropriate assignment of funding responsibility.

- At the service center level DMR should identify one staff person as the lead "Child/Adolescent Liaison" (if there is no such identified staff currently). This liaison will be responsible for assuring the determination of eligibility for children and adolescents, of assigning priority and developing a

profile of service needs, including Chapter 688 planning.

- During a transition period, the DMH children's coordinator will serve as technical assistant to the DMR Child/Adolescent liaison in order to assure no currently serviced clients "fall through the cracks" and to facilitate the DMR liaison's learning of, and participation in, the EOHS Interagency System. The DMH Children's Coordinator will also assist the DMR liaison in participating in Chapter 766 services and insuring coordination of services to court-involved youths.

- Clinical teams at the local level will include the DMR Child/Adolescent Liaison and the DMH Children's Coordinator, as well as skilled clinical staff. At the regional and central levels, the teams should include child/adolescent clinical staff from both departments. This will maximize flexible access to resources needed to meet unusual client needs. (See "Joint Programs" section.)

The Department of Mental Health

The new DMH will be responsible for the provision of mental health professional services, including acute hospitalization. However, as previously stated, the state hospitals and community mental health centers have been the providers of secure and emergency care and treatment for all the department's clients including those for whom acute hospitalization is not required or appropriate. This role will not be continued: DMR must develop the capacity to provide room, board, and security, and stop relying on the state hospitals and CMHCs to fill in service gaps.

The Role of State Hospitals

Problems of severe mental illness are dramatically increased for clients who also have diminished cognitive and expressive capabilities due to retardation. These individuals are generally less able, particularly while in a state of acute crisis, to handle the stimulation level found in most psychiatric facilities. Placement in such an environment often leads to further deterioration in functional abilities. In addition, the inability of some clients to communicate verbally may cause frustration, often resulting in aggressive and acting-out behaviors, which are frequently misunderstood by staff.

Two state hospitals have made efforts to serve the MR population with intensive psychiatric service needs. These programs are still in the beginning stages of development, and should not yet be considered as models on which to base other new

programs. For the present and near future, these specialty non-acute residential programs will continue to operate in the state hospitals. Over time, however, as DMR develops specialized residential programs, these units will become DMH acute psychiatric units for the mentally retarded/mentally ill population with very intensive specialized needs. DMR and DMH must share funding responsibility for these services during the transition period. It will also be necessary to develop interagency working agreements regarding referral, placement, and discharge. DMH and DMR should adopt a joint policy to encourage the private sector to develop specialized psychiatric services which can then be purchased for those clients who are mildly to moderately retarded, and who do not require as specialized a program.

To help assure suitable movement of DMR clients through the DMH hospital system, related financial incentives should be developed jointly by DMH and DMR. One reimbursement incentive which should be considered for dual-diagnosed clients on DMH inpatient units is a system of assigned "bed-days". Such a system, currently in use for the Adolescent Acute Diagnostic Units, has enhanced administrative accountability for use of intensive inpatient services. If such a system of "bed-day" allocation does not prove effective in reducing length of stay once discharge is authorized by the facility staff, a system of payment for each "bed-day" used over 115 percent of a planned quota could be implemented.

Community Mental Health Services

The Department of Mental Health will continue to be responsible for providing community mental health services, including provision of such services to DMR clients who can benefit from them. The Department of Mental Health will also be the lead agency in the development of clinics that specialize in the treatment of the mental health problems of the mentally retarded, though DMR will collaborate in development and provide financial support when necessary for its clients.

One or two clinics in each region will be targeted for development of specialized and comprehensive diagnostic, evaluation and treatment services for the dual-diagnosed population. Designated clinics will be responsible for assuring access to related specialty services, such as behavioral neurology, but may and probably should do so via arrangements with community hospitals and/or other local service providers.

Mental health emergency, evaluation, and consultation services will continue to be provided by DMH clinicians, but these services must be defined and standardized. A shared understanding of the objectives and scope of these services (and particularly the working definition of the term "emergency"), must be developed

and formalized between DMH and DMR, and affiliation agreements put in place at the service delivery level.

Mental Health Eligibility Criteria

While eligibility criteria for mental retardation services have been exclusionary and restrictive, mental health eligibility policy has been vague or non-existent. With the split, articulation and standardization of definitions of who is eligible for mental health services will become essential, particularly in regards to the dual-diagnosed population.

Joint DMH/DMR Programs

Most responsibilities relative to the dual-diagnosed client population can be assigned to either DMH or DMR. However, it should be stated explicitly, that all future policy development and program planning for this population should be conducted jointly regardless of primary agency assignment. Such planning and policy development will include, but not be limited to, the following:

- agency and program-specific eligibility criteria;
- expansion and/or improvement of mental health inpatient and outpatient services to the dual-diagnosed population and their families; and
- long-range budget planning for services that should be accessible to clients of either agency.

Additionally, continuation of interagency coordination of services to dual-diagnosed clients can be better assured by formalizing current, informal working arrangements. This will be accomplished via memoranda of understanding at the central office level, and affiliation agreements at the service delivery level.

The following sections identify the program areas requiring not only common planning and policy development, but joint administration and/or funding.

Interagency Clinical Teams

As stated earlier in this chapter, both DMH and DMR will have clinical resource teams at the local, regional, and central levels that will function under a shared set of policies and protocols. These teams will assist in identifying dual-diagnosed client needs and gaining access to both agencies' services. It is further recommended:

- That a joint, executive level clinical group be formed as a standing committee to serve as policy and program advisors during the entire split transition period;

- That a system utilizing these clinical teams for processing "stuck cases" be developed, with the joint central office interdepartmental team as final arbiter; and

- That a client fund, to be jointly financed by DMH and DMR, be made available for implementation of the central office interdepartmental team's decisions.

Research and Evaluation

Before informed program planning and policy making can take place, more needs to be learned about this population, and which segments might benefit from what kinds of services. It is therefore recommended that DMR and DMH embark on a joint program of related research and program effectiveness evaluation.

Education and Training

There currently exists within DMH some informal reciprocal in-service education and training arrangements between MH and MR personnel. These arrangements need to be formalized and expanded to include all levels of field and central office staff.

While interagency staff training will be a mandatory component of the new system, it cannot by itself address the tremendous shortage of professionals, skilled in serving the dual-diagnosed population. A supply of skilled professionals must be developed in all disciplines (including those with a sub-speciality in childhood and adolescent development issues) to staff new programs designed for serving this population.

Clinicians and administrators from both DMR and DMH will jointly initiate and sponsor a task force that will be charged with developing related education and training programs, with special attention to the clinical needs of dual-diagnosed children and adolescents. Deans of medical schools and of graduate schools training mental health professionals will be recruited for task force membership. This group will be responsible for development of internships, psychiatric fellowships, and field placements for such trainees in programs providing expert care and treatment to the dual-diagnosed population. Special effort will be made to insure that the trainee group reflects the cultural and ethnic diversity of the DMH and DMR client populations. Finally, the design of these education and training programs will include incentives for entering into the DMH and DMR service systems upon graduation.

CHAPTER FIVE

PROPOSED REGION/AREA CONFIGURATION

The first fourteen years of the Department of Mental Health area-based system were characterized by accelerated expansion of role, authority and resources. Areas, which began as minimal operations, grew to handle contract administration, business management and program development, as well as clinical and service coordination. At their most comprehensive, areas were responsible for clinical nurseries and early intervention programs, substance abuse, respite care programs, psychiatric inpatient units, and mental retardation services as well as the full array of community based mental health services.

During this period, the responsibilities of most areas grew significantly, but little in the way of standardization of function or management was required. Large variance in management practice, service orientation, client prioritization and operations resulted. Some variance in area operations is predictable and reasonable given the differing socio-economic profiles of communities and the impact of advocates and legislative eminence on resource allocation and vendor relationships. However, by the late 1970s, variation among areas extended to the very philosophical underpinnings of the department's mission as well as the services put forth to carry out that mission.

The area system was viewed by clients, providers, and outside critics as a patchwork quilt of service delivery systems with differing administrative protocols, resource levels, constituencies and service orientations. While certain individual areas were recognized locally as both comprehensive and accountable, even the best managed areas lost coherence when viewed against the array of systems across the state. The department generally was perceived as a balkanized system attempting to meet the needs of an inadequately defined client population.

Over the last several years, areas have undergone major changes. Responsibility for early intervention programs, clinical nurseries and substance abuse was moved to the Department of Public Health. The Department of Social Services picked up many MR respite services programs. Management of psychiatric inpatient units is now under the direction of Chief Operating Officers in each of the state hospitals. The DMH appropriation accounts have

been consolidated, control centralized and tighter procurement and expense processes have put in place. The Governor's recent Mental Health Special Message (1986) ended polemics regarding the department's mission and priority clientele. Care for "seriously mentally ill adults and children" was re-enforced by its inclusion in the law separating the Department of Mental Health. Finally, the passage of the bill to separate the Department of Mental Health has removed more than 50 percent of the responsibility remaining in the area offices. The responsibility for MR service delivery and accompanying administrative resources will move to the new Department of Mental Retardation during the course of the next 18 months.

Current Policy Considerations

Policy changes contained in this transition plan will further alter the size and scope of area responsibility for both the new DMR and DMH. Contract administration and support (i.e., personnel and budget functions) will be managed at the regional level, while area offices will continue to be responsible for direct operation of mental health case management services and mental retardation service coordination, as well as program monitoring.

While functions of DMR and DMH area offices will change significantly, several aspects will remain the same. Areas will continue to benefit from citizen participation via local Area Advisory Boards. Clients will continue to receive services in program sites at various locations within a community and not at area offices. In the event that the new local structure results in access difficulties for clients or families, both new departments are prepared to make adjustments to alleviate the problem. Areas will continue to participate in the contract process especially in the area of contract specifications, vendor selection and program monitoring.

Area Consolidation

The changes discussed above make re-examination of existing area boundaries prudent. The scope of responsibilities proposed for both DMR and DMH local offices do not warrant the fiscal and administrative overhead required to maintain the number of areas now supported. There is little justification to maintain such small geographic areas.

Management Efficiencies

Area consolidation will decrease duplicative bureaucracies, minimize fiscal and administrative functions and refocus resources toward client services. If the area structure as currently

configured were to remain intact and be duplicated, bureaucracy would be sustained at the expense of client service productivity.

The primary purpose of local area offices will continue to be allocation of services to priority clients based on individual needs. To accomplish this, areas need a critical mass of services including sufficient types and levels of services to ensure flexible and clinically appropriate responses to individual needs. Small geographic areas with limited service resources have failed to achieve this critical mass. The existence of small areas with less flexible service resources has resulted at times in maintaining clients at inappropriate levels of care or in not having a particular service to meet specialized client needs. Consolidation will produce larger geographic areas which will result in more cost effective development and management especially in the area of specialized programs for low-incidence needs. Consolidation will bring the areas closer to the goal of a comprehensive range of services.

Resource Allocation and Resource Compartmentalization

There are currently vast differences both in service dollars and in the configuration of service systems among the 40 areas. A client presenting for service in the Cape Cod or Solomon Carter Fuller area may receive something very different from what the same client will get in Concord or Cape Ann. Clients should receive consistent treatment wherever they live or request services. A smaller number of areas will facilitate equitable delivery of services and resources as well as ensure consistency in service system design.

Clients living in relatively small geographic areas have currently little or no access to services, however appropriate or available, in adjoining areas. This exacerbates the problems of resource inequities noted above. Currently no mechanism exists for matching the needs of priority clients with available resources across the geographic boundaries. For instance, a vacant residential slot in Lowell will remain vacant awaiting placement of a Lowell client, even if there are 10 clients who need residential services waiting in nearby areas. Also, clients living in one area and receiving services cannot move to an adjacent area and expect to continue receiving these same services. Service resources stay with the area, and not with the client. The larger the number of areas, the greater the potential that this type of problem will be magnified. The proposed consolidation of areas, in conjunction with the expanded role of regions, will significantly alleviate this problem.

The recommended region/area configurations for DMR and DMH are shown in Table 5-1. The only difference between them is in the Metro Region (Boston) where DMR specifies three separate local service centers. For DMH, Boston service locations remain

unspecified. For administrative purposes in DMH, Boston is considered both an area and a region.

Summary

The purpose of area consolidation is to achieve a reasonable and cost effective balance between responsive local client service management and resource management. Given the change in scope of responsibility, and the appropriately narrowed focus of areas on serving clients, the enlargement of area boundaries is expected to result in equally manageable entities. Major improvements in correcting the problems of resource inequity and compartmentalization can also be anticipated.

Variables that were considered in the deliberation of which local service centers will be combined included population projections for 1990, numbers of clients served and waiting to be served, sociodemographic and needs assessment data, the geographical relationship among communities, and transportation access routes. Maintaining congruence with the regional boundaries of other EOHS areas was also an important criterion.

TABLE 5-1

REGIONS AND DMR LOCAL SERVICE CENTERS/DMH AREAS

Region 1

1. Franklin-Hampshire
2. Berkshire
3. Springfield/Westfield
4. Holyoke/Chicopee

Region 2

5. Worcester
6. South Central/Blackstone Valley
7. North Central

Region 3

8. Lowell
9. Lawrence/Haverhill-Newburyport
10. Danvers-Salem/Cape Ann
11. Eastern Middlesex/Tri-City
12. Lynn

Region 4

13. Newton-Wellesley-Weston-Needham/South Norfolk
14. Concord/Mystic Valley/Metropolitan-Beaverbrook
15. South Shore/Coastal
16. Marlboro-Westboro/South Middlesex
17. Cambridge-Somerville

Region 5

18. Taunton/Attleboro
19. Plymouth
20. Fall River/New Bedford
21. Cape Cod and the Islands
22. Brockton

DMR Region 6

23. Harbor/Bay Cove
24. Dorchester-Mattapan/ Solomon Carter Fuller
25. West-Ros-Park/Mass. Mental

DMH Region 6

23. Metro Boston (including Suffolk County and Brookline)

CHAPTER SIX

PLAN FOR SEPARATING PERSONNEL AND INVENTORY

The separation of the Department of Mental Health requires the allocation of more than 19,000 employees (see Table 6-1) and all real and personal property held or leased by the department. In this chapter the plan governing the separation and allocation of personnel and inventory is outlined.

Personnel

Chapter 599 of the Acts of 1986 includes a series of mandates relevant to the separation of the department's human resources. The law requires that the department:

- develop a specific plan governing the allocation of positions between the Department of Mental Health and the Department of Mental Retardation;
- develop a specific plan governing the assignment of employees to the two departments;
- ensure continuity of services to the public during the transition period;
- ensure that no employees suffer loss of pay or rights due solely to the separation.

In view of the complexity of the department's organizational structure, and the legislative mandate to ensure continuity of services, it is neither realistic nor desirable to effect all personnel aspects of the separation simultaneously. The process for position allocation and personnel assignment will, therefore, occur in three separate phases, which will commence no later than July 1, 1987 and conclude no later than June 30, 1988.

For the purposes of transition planning, the personnel of the department will be grouped into three major categories. The categories are: 1) Division of Mental Health and Division of Mental Retardation (central office, institutional and state operated ICF-MR positions); 2) field operation positions; 3) general administrative and professional positions. They will be reassigned in three phases:

Phase 1: Mental Health and Mental Retardation Services

- Division of Mental Health Services:
  All central office division staff including hospital management, community programs and operations, child adolescent services, and forensic mental health services, as well as seven state hospitals, Bridgewater Treatment Center, Gaebler Children's Center.

- Division of Mental Retardation:
  All central office division staff, mental retardation facilities, and state operated ICF-MR's

During Phase 1, all above specified employees and positions in the Division of Mental Retardation will be assigned to the Department of Mental Retardation. Similarly, all above specified employees and positions in the Division of Mental Health will be assigned to the Department of Mental Health. The implementation of this phase will occur no earlier than July 1, 1987 and no later than September 30, 1987.

All of the management and non-management Phase 1 employees will retain the job title, position number, level of pay, location, job duties, civil service and/or collective bargaining status that they held the day prior to the separation of the department.

All of the above Phase 1 employees will continue to perform all services provided by them prior to the separation during the course of the transition. Cross agency personnel responsibilities which currently exist will be identified and formalized by interagency agreements. No such identified responsibilities shall be discontinued without agreement by both agencies.

Phase 2: Field Operations

- All area office, district office, community mental health center, Forensic Mental Health and Child-Adolescent field positions.

Field Operation positions to be reassigned in the second phase include both management and non-management employees. Field positions governed by collective bargaining will be reviewed to determine what percentage of time is spent on MR or MH activities. That aggregate percentage for all positions will be used to determine the overall allocation of positions between the two agencies. These employees will retain the job title, level of pay and any civil service and/or collective bargaining rights that they held the day prior to the separation. However, these employees may be subject to changes in work location or job duties as a result of changes in the organizational structure of the two agencies. The specific criteria and procedures to be used in assigning employees to positions in the new agencies will be determined by collective bargaining.

Management positions in Phase 2 will be equitably distributed to the two new agencies based on mutual agreement of the two commissioners. Phase 2 transfers will begin no later than January 1, 1988 and conclude no later than March 31, 1988.

Phase 3: General Administrative and Professional Support

- Division of Clinical and Professional Services (including Quality Assurance and Licensing)
- Division of Management Services (including Service Bureaus, Facilities Management, Human Resources, Administrative Services and Management Information Services)
- Office of the commissioner (including Policy and Planning, Legislative Affairs, Public Information, Human Rights, Client Services, Internal Affairs, Affirmative Action and General Counsel).

The last phase will be implemented in the final quarter of FY'88. All employees in Phase 3 perform services for both agencies and therefore, will need to be allocated at the conclusion of the transition period. This will allow both agencies sufficient time to effectively separate and replicate these services. The method used to allocate management and non-management employees will be the same as that used in Phase 2.

Assignment To Management Positions

Assignment of employees to management positions within the two agencies in both Phase 2 and Phase 3 will be based on criteria and procedures which are currently being developed but at a minimum will include:

1. Consideration of a manager's preference concerning location and duties.
2. Notice to current managers of new positions available.
3. First consideration for persons currently employed for any vacant management positions.
4. Commitment to equal opportunity and affirmative action.

Exceptions to the general three phase process described above maybe made by the Commissioner of Mental Health after consultation with the Commissioner of Mental Retardation wherever he or she determines that either the accelerated or delayed allocation of one or more positions is necessary to accomplish the overall purposes of this transition plan.

Oversight responsibility for all Human Resource activity within the Executive Branch rests with two agencies; the Office of Employee Relations and the Department of Personnel Administration.

The organization or reorganization of the two new agencies will result in significant changes in many managers' current responsibilities. The Department of Personnel Administration is responsible for evaluating all management positions and establishing the level of pay based on the position's responsibilities. Therefore, the department does not possess the authority to guarantee managers the same level of pay when the separation is implemented. The department will, however, seek executive and legislative approval to preserve the salary of managers, regardless of any changes in responsibility, for at least a one year period following the separation.

Inventory

In addition to personnel, there are many tangible assets to be separated. Assets which will be separated as a result of DMH separation are categorized into four groups as follows:

- Furniture and Equipment. Items which have a purchase price of $100 or more and a useful life of at least two years are considered furniture and equipment with the exception of computers. Such items include: beds, tables, desks, typewriters, telephones, automobiles, etc.

- Computers. Hardware and software for micro and Mainframe computers.

- Office and Program Space Leases. Agreements with landlords for the rental of office and program space.

- Land and Buildings. Any piece of land or building assigned to the department irrespective of current use.

Assignment of tangible assets requires an inventory of assets to be separated. These inventories will be used to ensure equity in the final distribution. The resource identification process follows.

- Furniture and Equipment. Although the department has a central computerized inventory system, records in many instances were incomplete.

  Each location was sent a detailed printout of the inventory and requested to verify for completeness and accuracy of the listings. Locations which did not have

inventories listed were required to undertake and complete an inventory.

Inventories for all area offices, community mental health centers, state operated programs, and the central office are completed. Inventories for state schools and hospitals will be completed by the end of May. Finally, inventories for vendor operated programs will be completed by the end of April.

- Computers. Records for all computers are complete and up-to-date.

- Office and Program Space Leases. The department has 28 leases for the rental of a central office, a service bureau, 22 area offices, and four program sites. The standard term is five years but several are tenancies at will. Nine leases are expired or near expiration.

- Land and Buildings - Inventories of land and buildings must be updated. Official records, as maintained by the Comptroller, have been sent to department locations for verification and correction as necessary. The land and building inventory will be completed by the end of March.

  Several department locations are in public facilities operated by other sub-divisions of the Commonwealth; the terms and square footage of many of these locations are not currently available. The details of these agreements will be collected by the end of March.

  Many tracts of land have buildings serving different client groups. For example, there are Intermediate Care Facilities for the mentally retarded located on the grounds of state hospitals for the mentally ill. The identification of plot boundaries for these buildings will be completed during the transition year.

Assignment of Resources

Resources will be assigned to the Department of Mental Retardation and unless otherwise specified, the balance remains with the Department of Mental Health. Given that much resource distribution must occur as a result of analyses not yet complete, a resource decision committee will be appointed to make judgments about distribution during the transition period. Specific gaps in resources which may arise during the transition process will be addressed in a separate section. The rationale for resource assignment follows.

- Furniture and Equipment. Furniture and equipment at facilities involved solely with the care and

administration of services for the mentally retarded will be assigned to the Department of Mental Retardation. In locations which provide administrative services to the mentally retarded and mentally ill, individual assignments will be based upon the recommendations of the Personnel Committee. That is, furniture and equipment follow people.

As individuals are assigned to the Department of Mental Retardation, the furniture and equipment they personally use will be so assigned. Common items such as reception furniture, copy machines, and telephones will be assigned if the location is assigned to the Department of Mental Retardation.

- Computers. Assignment of the Computers will be done after an analysis is completed. The organizational needs for each department must be determined and then assessed against existing computer resources. Assignments will be made which equitably balance needs with resources.

- Office Program Leases and Land and Buildings. Leases, land, and buildings are centrally controlled by the Commonwealth. Any assignment to the Department of Mental Retardation requires notification of the Executive Office of Human Services and the Division of Capital Planning and Operations.

The assignment of land and buildings which solely serve the mentally retarded, will be done in July, 1987. These include:

- Belchertown State School
- Dever State School
- Fernald State School, including Templeton Colony
- Foxboro State Hospital[1]
- Glavin Regional Center
- Hogan/Berry Rehabilitation Center[2]
- Monson Developmental Center
- Wrentham State School

Assignment of other land and buildings as well as leases will be made after the space needs of both departments are determined.

---

[1]Foxboro State Hospital is closed as a facility for the mentally ill. The campus is managed by the Superintendent of the Wrentham State School. Several buildings currently house mentally retarded clients. Other buildings are slated for or occupied by the Criminal Justice Training Committee or the Executive Office of Human Services.

[2]Hogan/Berry Rehabilitation Center and Danvers State Hospital share a campus. A detailed agreement between DMH and DMR will be negotiated. It is not anticipated that the property will be subdivided.

These needs must be balanced against the availability of space in department facilities, leased sites, other public buildings currently occupied by the department, and other possible locations in facilities operated by the Commonwealth.

Co-locations may be the most appropriate conclusion in some cases. In these instances, one department will have management control of the facility with use of space agreements with the other. Use of space agreements may also be developed with other agencies of the state.

Issues Resulting from Reassignment

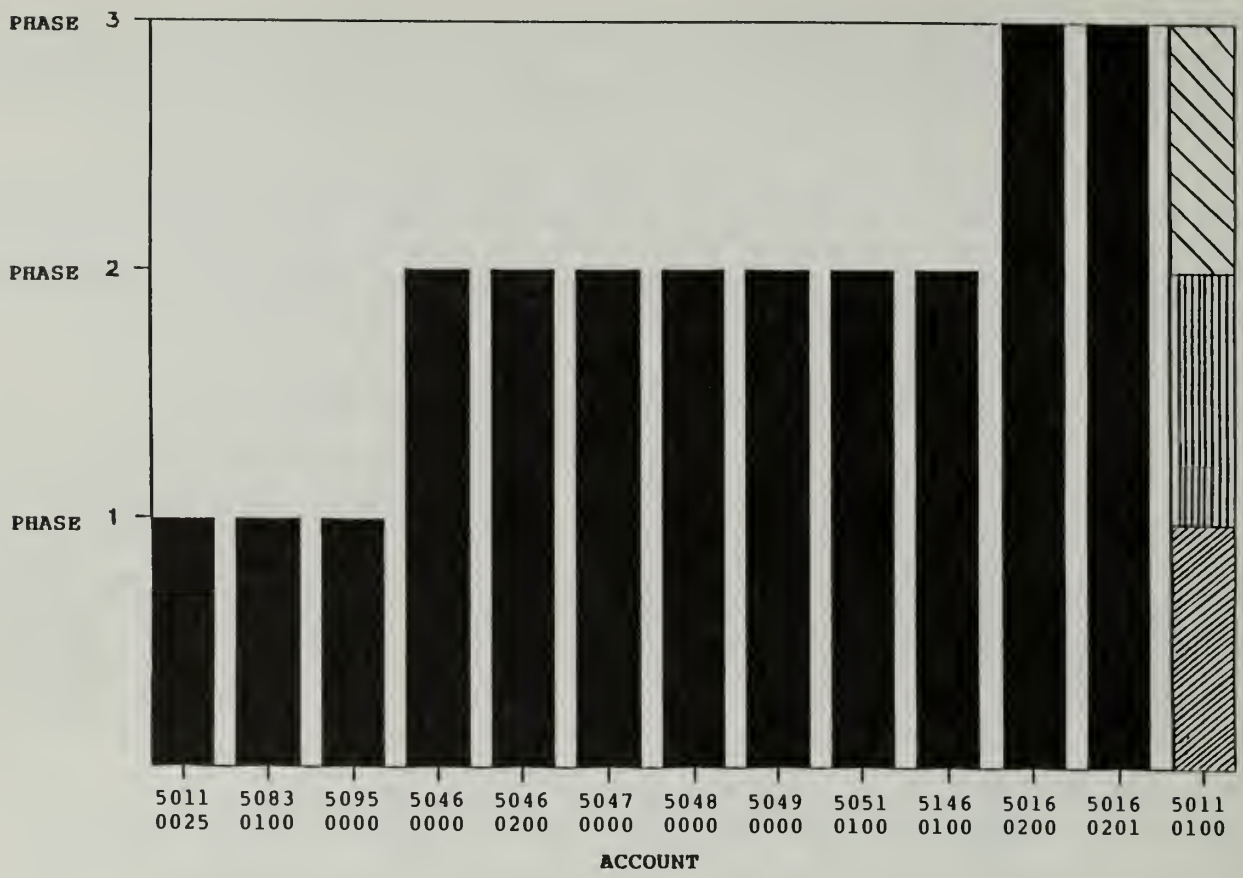
In order to make equitable assignments of resources to the two new departments, resource needs must be assessed. The assessment of needs will be based on the organizational structures of the two departments, and the availability of existing resources. Assignments will be made which equitably balance needs with existing resources. However, the needs of the proposed structures may result in gaps in existing resources, requiring expansion or addition of new resources. These areas of need are briefly described below.

- Area/Local and Regional Office Space. One such resource gap which can be identified is the space requirement for administrative offices. Currently, space needs are being projected on the basis of preliminary staffing models and existing staffing configurations in area and regional offices.

- Computer Resources. A second area which may require expansion of existing resources is computers. The system needs of the two departments are being assessed, and costs of required additions or system changes are being projected.

TABLE 6-1

STAFF PHASE-IN PROCESS



APPROP. ACCT.	CATEGORY	FTE	FY 1987 $
5011-0025	Transportation	5	19,519,436
5083-0100	Facilities for MR	10554	235,417,336
5095-0000	State Hospitals	4751	115,000,101
5046-0000	Adult - MH	721	57,799,865
5046-0200	Reserve - MH/MR Forensic/Child Adolescent	17	9,561,666
5047-0000	Child/Adolescent	164	34,732,829
5048-0000	Community MR	543	130,321,494
5049-0000	Forensic MH	82	3,894,140
5051-0100	Community MH Centers	2575	64,649,900
5146-0100	MH Services - District 1	142	31,507,346
5016-0200	Research - MH	5	400,000
5016-0201	Management Improvement	40	600,000
5011-0100	Administration	784	31,409,455

- C.O. MH & MR Services staff
- Field Operations Staff including Area & Associate Area Dirs. & Support staff
- C.O. General Administration Staff
- Entire Account

CHAPTER SEVEN

TRANSITION SCHEDULE

Separation of DMH into two departments is a dynamic process. Its substance has been explained in Chapters Two and Three, with one of its major implications, the effects on dual-diagnosed and special needs clients, considered in Chapter Four. The complexity of issues described in those chapters impacts greatly on the determination of a transition schedule. Development of a schedule is, in fact, exceedingly difficult. It is difficult because setting target dates requires consideration not only of all the actions that will need to be taken to achieve a particular objective, but also all of the barriers which might delay or prevent timely completion.

Listing actions to be taken is possible, but forecasting which delays will occur and which barriers will present during the transition is impossible. The only option is to build in small amounts of "potential delay" time in the hope that such slack will allow the overall project to stay on course. This schedule is based on those conditions. Thus, all time frames are estimates, but all end dates are critical to keeping the project on course. It is essential, however, that the Commissioners of DMR and DMH retain the authority to reset schedules as the project unfolds, so that estimates and forecasts do not themselves become barriers to project completion. What follows then, are transition schedules which move DMH into separate departments by June 30, 1988. They are presented in several segments which represent main goals of transition, which are:

- Transition to separate central, regional and area offices, Included in this goal are transfers of authority, personnel, land, inventory, equipment and regulations;

- Transition to two separate systems for citizen participation;

- Transition to an effective interagency service system for dual-diagnosed and special needs clients;

The transition schedules are premised on the following:

- That all current authorities, responsibilities, and working relationships will continue as is until dates

specified for transfer, or actual transfer dates should those be different from specified dates. This applies to all employee, contract, management structure, working agreements, and citizen participation mechanisms. It is designed to minimize misunderstandings about "Who's in charge?";

- That all "end dates" specified are to be interpreted to mean "not later than." However, the department intends to encourage acceleration of transfers where possible: the "not later than" definition permits flexibility;

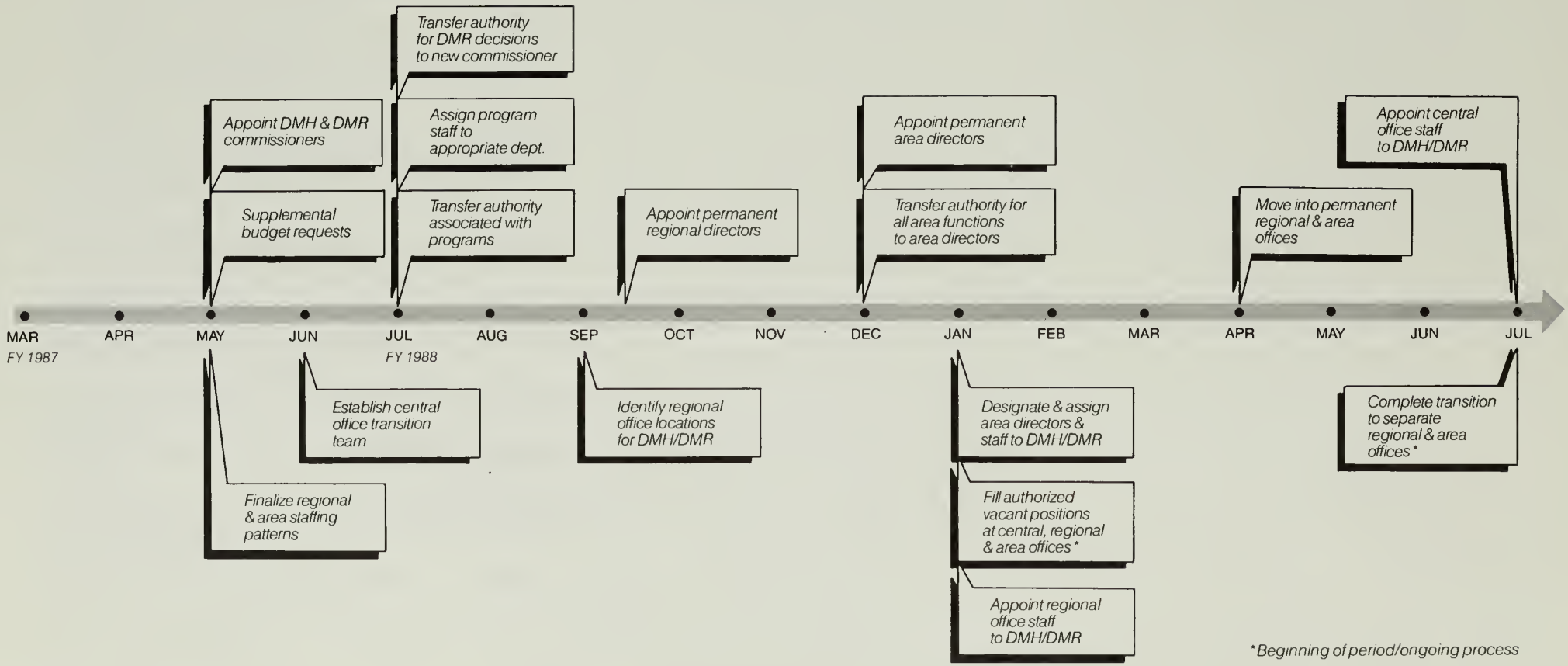
- That action steps stated represent major decision points, not the totality of activities and decisions necessary to effect transition. That is, dozens of activities and decisions are subsumed under each action step stated;

- That separation of shared activities implies a two-step process of specialization, then separation. Thus, even though some units may not be recommended for separation until June 30, 1988, individuals within those units who are not now specialists in the work as it applies to mental retardation or mental health should be designated to one or the other and begin to specialize before they are separated.

In addition to these premises, a caveat is proposed: the path to prediction, like another well-known path, is paved with good intentions. Timetables herein are realistic, but they presume good intentions on the part of all participants, and they anticipate no extraordinary barriers. That is, staff must be alert to barriers which will render these timetables invalid, so that adjustments can be made and communicated.

Transition Schedule

A summary of the major target dates toward developing a new system

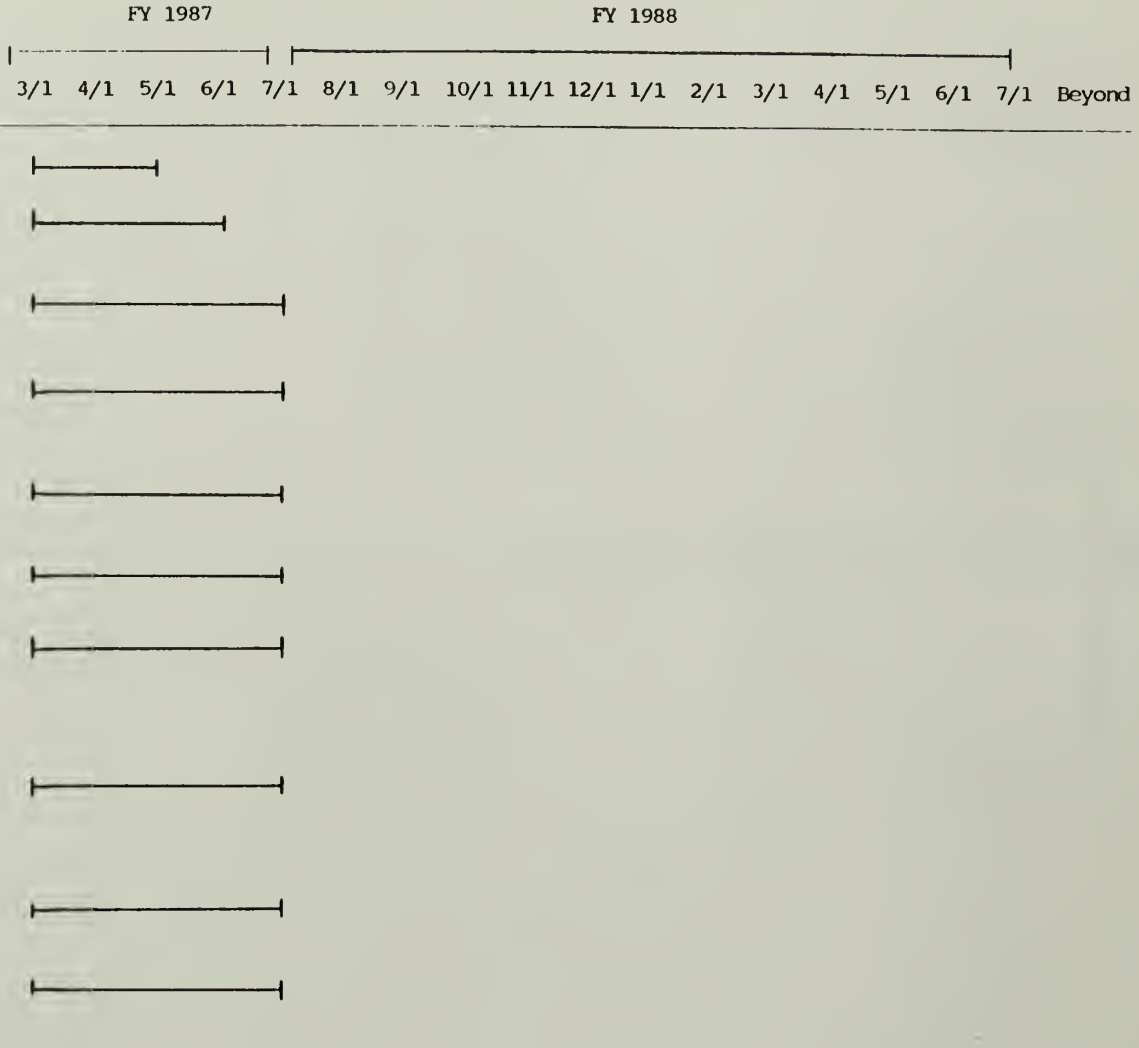


*Beginning of period/ongoing process

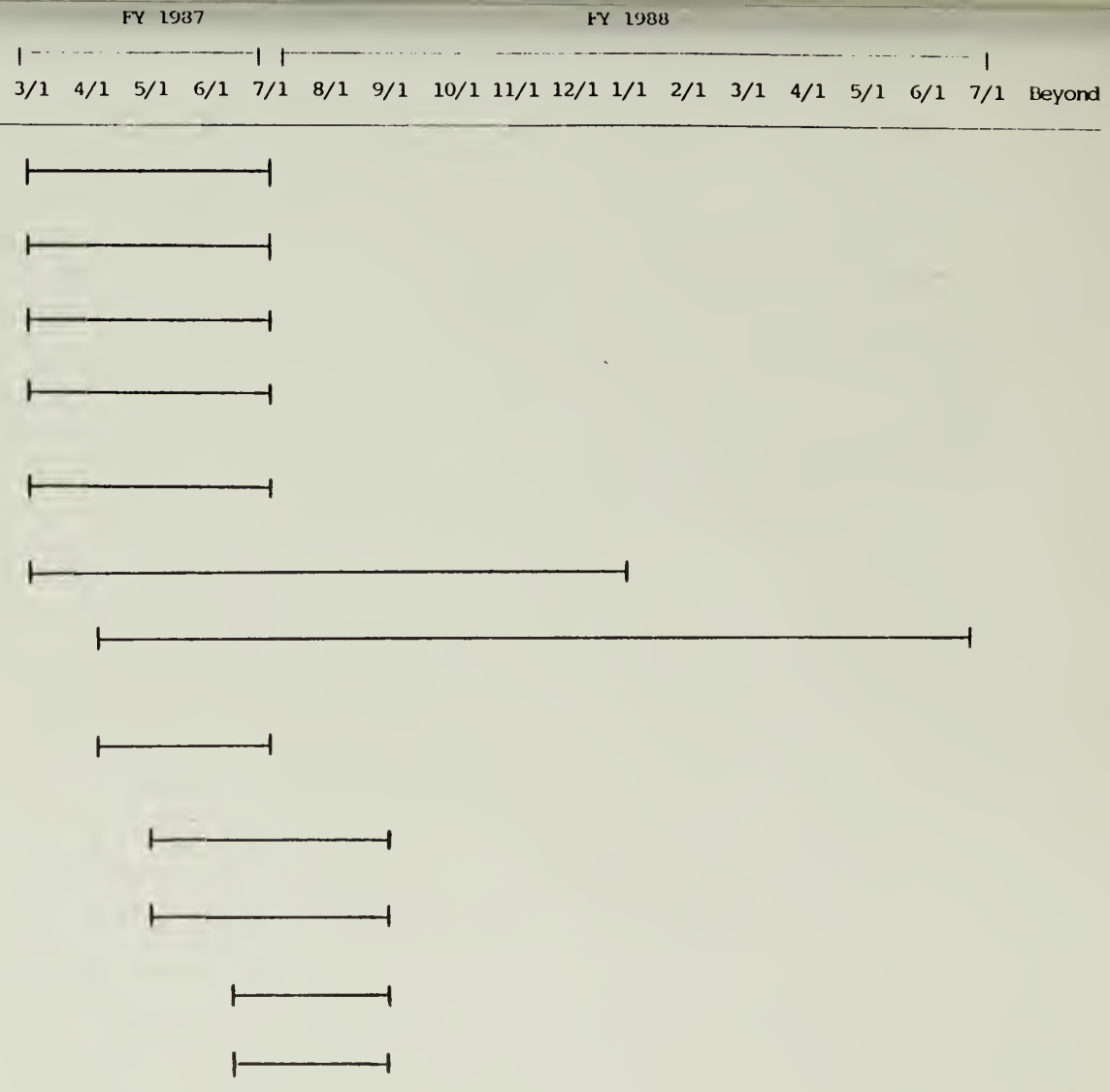
TRANSITION SCHEDULE

GOAL SEPARATE, FULLY FUNCTIONAL CENTRAL, REGIONAL, AREA AND LOCAL OFFICES FOR DMH AND DMR

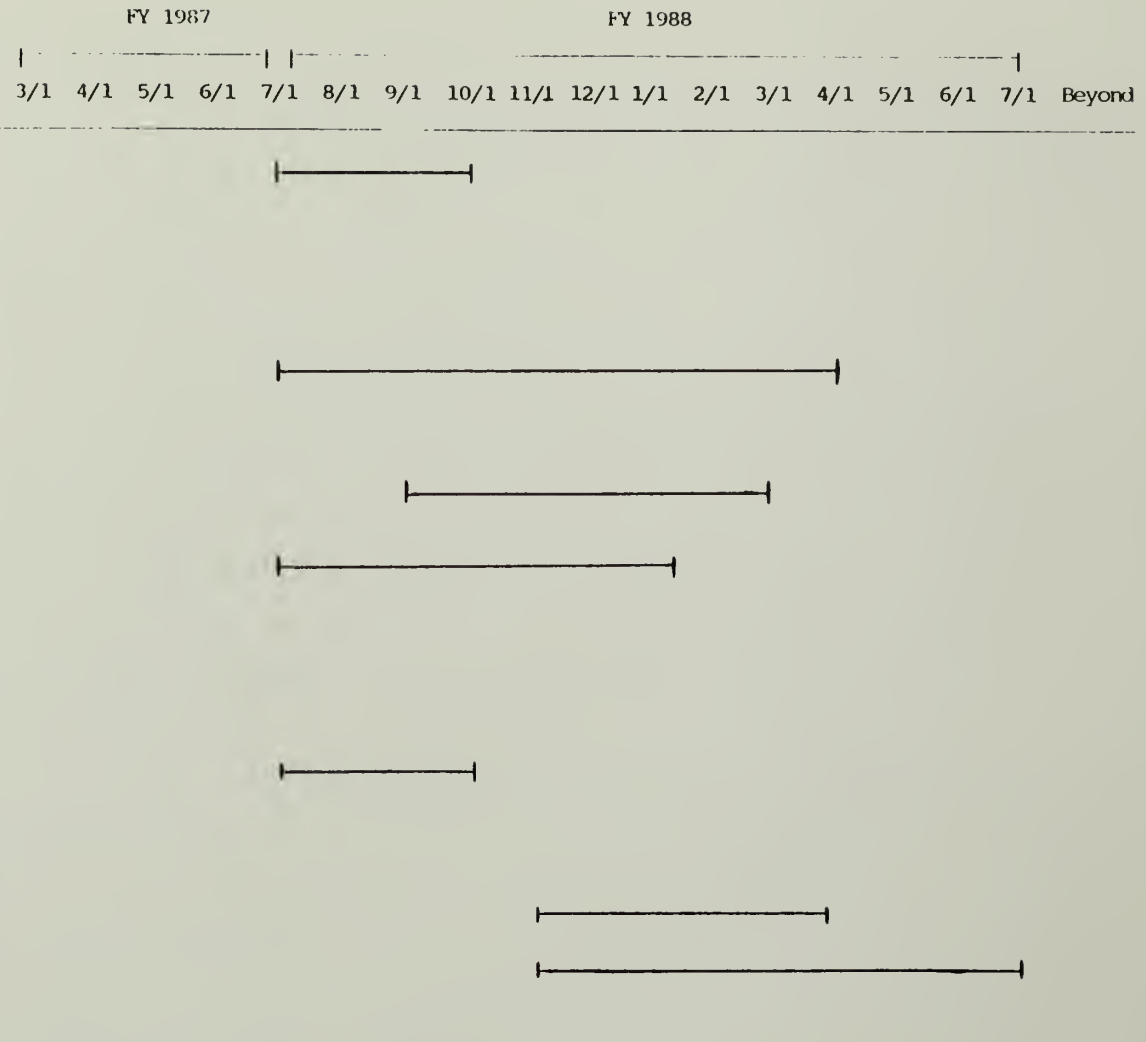
GOALS/TASKS	RESPONSIBLE PARTY
Search, Select and appoint DMH/DMR Comm.	Governor, EOHS
Establish interim and long-term DMH/DMR staffing requirements	DMH/DMR
Identify interim and long-term DMH/DMR budget adjustments	DMH/DMR/EOHS A&F/Legis.
Establish procedures for personnel and position surveys, postings, applications and assignments	DMH/DMR
Develop and promulgate Interim DMR regulations and policies regarding DMR structure, programs and client rights	DMR
Develop and promulgate DMH regulations regarding structure	DMH
Develop and execute Master DMH/DMR Inter-agency Agreement	DMH/DMR
Pursuant to Master Agreement:	
- Establish Joint Transition Planning Committee with Sub-Committees for Personnel, Inventory and other issues as needed	DMH/DMR
- Transfer State School Personnel and Central Office Division of MR Personnel to DMR	DMH
- Transfer Fiscal and Program Authority and Responsibility for State Schools to DMR	DMH



GOALS/TASKS	RESPONSIBLE PARTY
- Transfer Central Office level Program Authority and Responsibility for Community MR services to DMR	DMH
- Provide for DMH Regional and Area Maintenance of Community MR services	DMH
- Provide for DMH provision to DMR of Fiscal and Support services	DMH
- Provide for development of other DMH/DMR Interagency Agreements as needed	DMH/DMR
- Provide for later adjustments of Authority and Responsibility to follow after Regional, Area, Local and Central Office Staff assignments	DMH/DMR
Appoint Senior Staff of DMH/DMR	DMH/DMR
Finalize all inventories, assess and assign space, equipment, computer and personnel for DMH and DMR	DMH/DMR
Assign land and buildings to DMR: Belchertown, Dever, Fernald, Templeton, Foxboro State Hospital, Glavin, Hogan Berry, Monson, Wrentham	DMH/EOHS/A&F
Search/select and appoint permanent regional directors	DMH/DMR
Identify regional office locations for DMH and DMR	DMH/DMR
Establish area and local office transition teams	DMH/DMR
Identify area and local office locations for DMH and DMR	DMH/DMR



GOALS/TASKS	RESPONSIBLE PARTY
Assign Personnel and Positions (with exceptions) Account 5083-000 to DMR (10,601) Account 5095-000 to DMH (4,901) Account 5011-0025 to DMR (5) 5011-0010 to DMR (those functionally assigned)	DMH
Assignment of other land, buildings, leases	DMH
Agreements for co-located space	DMH/DMR
Search, select and appoint area and local service center directors for DMH and DMR consolidated areas	DMR/DMH
Assign Personnel and Positions: Account 5051-0000 (2,575) 5046-0000 (721 + 17) Reserve MH-Forensic 5146-0000 (142) Serv. Bur. 5047-0000 (164) C/A 5048-0000 (543) DMR 5049-0000 (82) Forensic MH	DMH
Assignment of personally needed equipment and furniture for personnel in Accounts: 5083-0000, 5095-0000, 5011-0025, 5011-0010, 5051-0000, 5046-0000, 5146-0000, 5047-0000, 5048-0000, 5049-0000	DMH
Move into regional, area and local offices	DMH/DMR
Acquire authorized equipment and furniture for central, regional, area and local offices	Regional Dir.



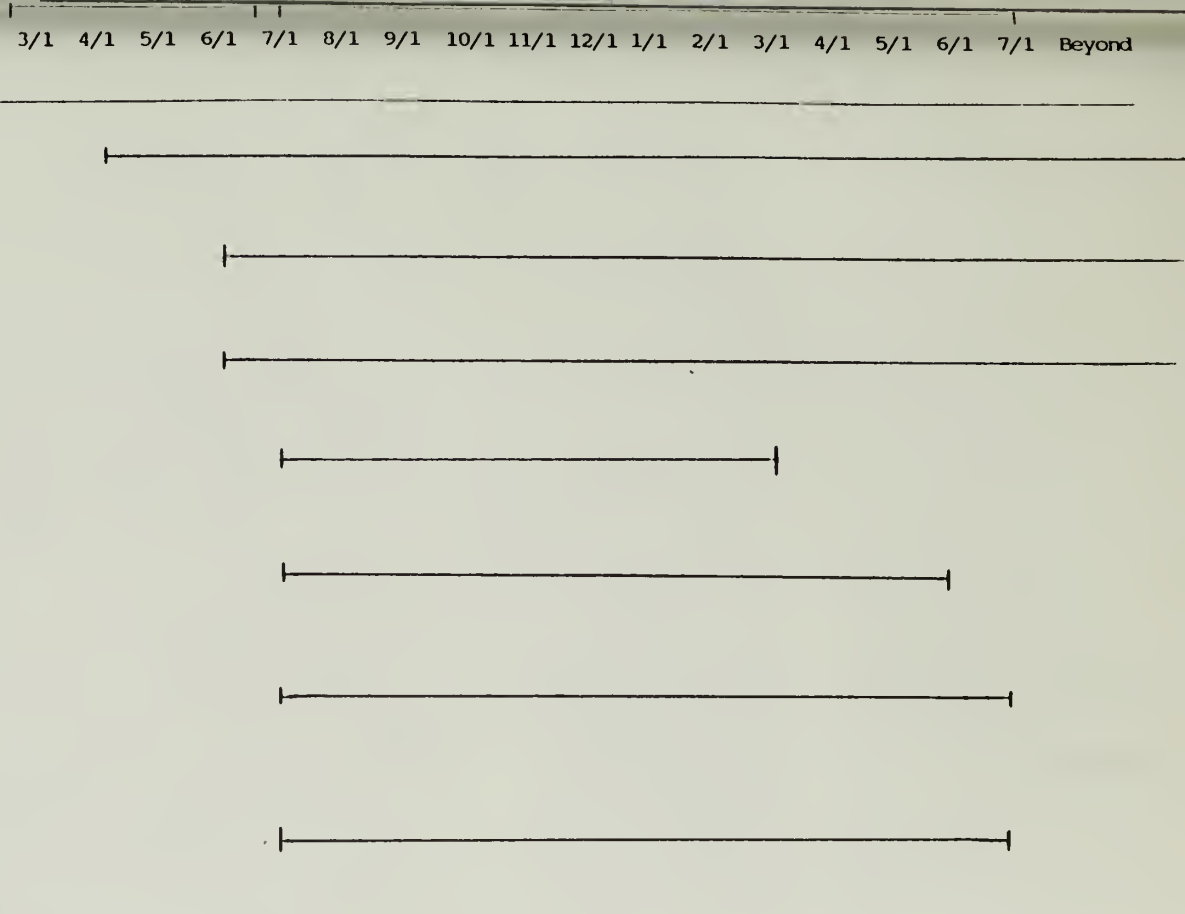
GOALS/TASKS	RESPONSIBLE PARTY	FY 1987					FY 1988											
		3/1	4/1	5/1	6/1	7/1	8/1	9/1	10/1	11/1	12/1	1/1	2/1	3/1	4/1	5/1	6/1	7/1	Beyond
Assign Personnel and Positions: 5011-0001 (784 - Admin.) 5016-0200 (5-MH Research) 50160201 (40 Admin.)	DMH																		
Fill authorized vacant positions at central regional, area and local offices	DMH/DMR																		
Relocate DMR/DMH central offices as necessary	DMR/DMH																		
Announce independent functioning, separate central offices	DMH/DMR																		
Complete transition to separate regional and area offices	DMH/DMR																		

TRANSITION SCHEDULE

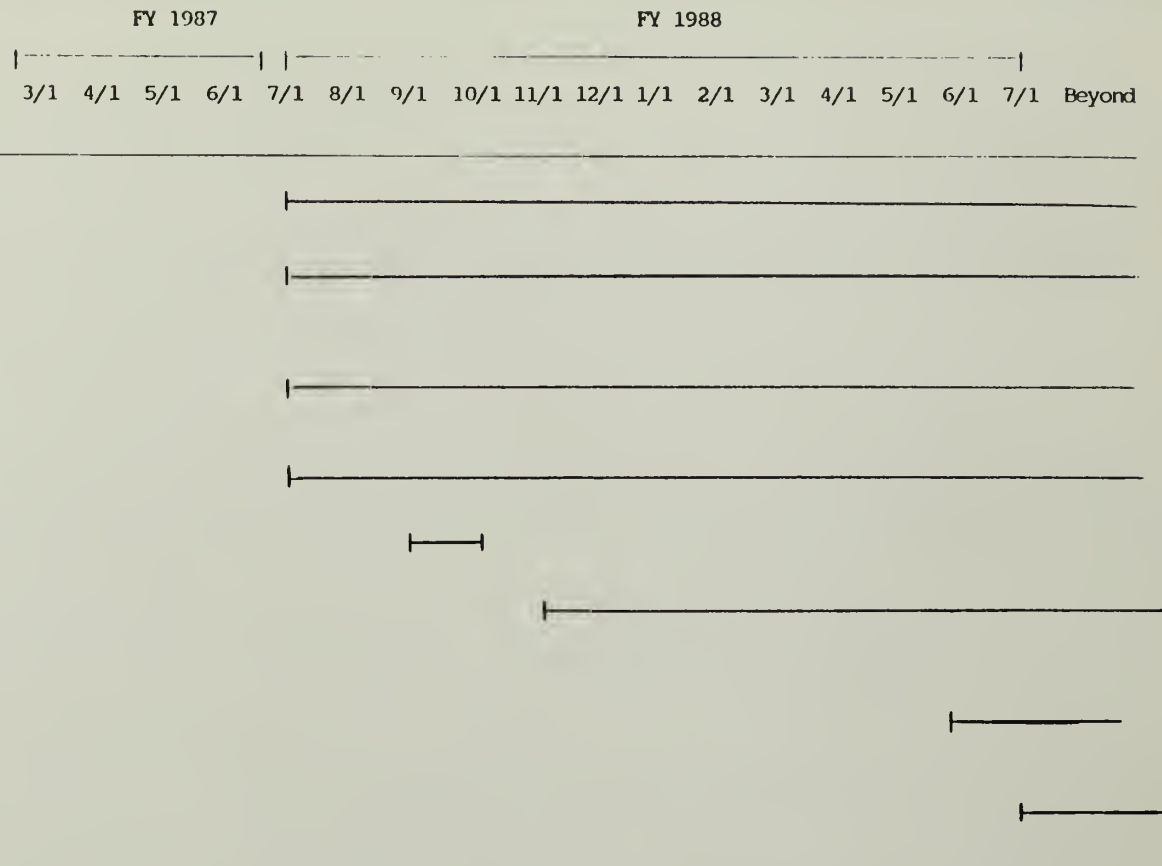
PROVIDE APPROPRIATE SERVICES FOR
DUAL-DIAGNOSED AND OTHER
SPECIAL NEEDS CLIENTS

GOALS/TASKS	RESPONSIBLE PARTY	FY 1987					FY 1988												
		3/1	4/1	5/1	6/1	7/1	8/1	9/1	10/1	11/1	12/1	1/1	2/1	3/1	4/1	5/1	6/1	7/1	Beyond
Review eligibility process for MH & MR clients	DMH/DMR																		
Identify all clients throughout system who are dually funded by DMH/DMR	DMH/DMR																		
Convene joint executive level clinical group to provide policy direction to planning, implementation, and evaluation of MR/MI services	DMH/DMR																		
Identify and review all agreements currently in force at the central, regional and area levels	DMH/DMR																		
Conduct research & needs assessment to inform program planning	DMH/DMR																		
Develop program models & budgets for DMR specialized emergency treatment & respite services	DMH/DMR																		
Develop program models and budgets for post-acute, transitional, intermediate stay, and long-term residential services for ED/MR and MR/MI populations	DMH/DMR																		
Prepare plans for MR clients currently in state hospitals and CMHCs	DMH/DMR																		

GOALS/TASKS	RESPONSIBLE PARTY
Assign Area children's coordinators to provide technical assistance to MR counterparts during transition period	DMH
Interim agreement between DMH and DMR to "hold harmless" all community programs currently funded jointly	DMH/DMR
Develop joint policy to encourage development of specialized psych services for dual-diagnosed in the private sector	DMH/DMR/RSC/EOHS
Develop reimbursement incentive system to move DMR clients from inappropriate DMH beds	DMR/DMH/RSC
Develop and finalize interagency agreements between DMR and DSS, OFC, MRC, MCB DPW, and LEAs at secretariat, central, regional and local levels as appropriate	DMR et al.
Develop and finalize interagency agreements between DMH and DMR in the following areas: forensic services, emergency services, children's services, interagency training, consolidated laundry, and resolution/funding of problem cases	DMH/DMR
Designate clinics throughout state to develop capacity to provide specialized MR/MI diagnosis, evaluation, treatment	DMH



GOALS/TASKS	RESPONSIBLE PARTY
Assign case management responsibility to DMR for all dual-diagnosis population	DMH
Assign full-time staff person at DMR central office to develop plans for children's MR and MR/MI services	DMR
Convene Joint Task Force to begin development of MR/MI education and training programs	DMH/DMR
Begin DMR representation on EOHS Interdepartmental Children's Team	DMR/EOHS
Submit FY89 program budget requests	DMH/DMR
Identify lead persons at regional and local levels to be responsible for services to MR and MR/MI children and adolescents	DMR
Begin change of current MR State Hospital units to specialized acute psych MR units	DMH
Complete implementation of necessary programs (as specified above) to create two independent functioning agencies	DMH/DMR



CHAPTER EIGHT

FINANCIAL FORECAST

By their action to separate DMH, the Governor and legislature have stated clearly that the benefits of serving mentally retarded and mentally ill citizens with separate departments outweigh the costs of separation. These benefits have been argued elsewhere: they range from greater responsiveness to clients' needs to better accountability. That the legislature recognized that costs will be involved is apparent in Chapter 599, Section 54: "Said transition plan shall include... necessary revisions to the budgets of said departments...."

Mergers of organizations often are justified on the basis that economies of scale will result, but splitting an agency has the opposite effect. That is, diseconomies of scale occur. For example, an area office serving both MR and MH populations has numerous economies of scale that will be lost when the functions are separated. Each existing office replicated in both new agencies will require two directors and support staff, two offices to rent, two personnel computers and other office equipment, two telephone systems, two trash collection and office cleaning contracts, two parking lots to be snowplowed, two area boards to be communicated with, etc. Obviously the entire staff of the office will not have to be replicated, but some of the resources-personnel and otherwise - that do not directly serve only the MR or only the MH function - but provide support to both, will have to be duplicated. To put the diseconomies argument into perspective, it should be noted that even if it could be precisely estimated that economies attendant to a single agency were equal to two percent of the total budget, the cost of separation would be $16 million (.02X800M).

Recognition of inevitable costs does not, however, answer the question, "How much cost?" Nor does it speak to where costs will occur or when they will occur. These questions can only be answered by analyzing separation prospects in the context of good management principles. The most basic management principle is efficiency, here defined as minimizing costs associated with effective client service. Efficiency has been the driving principle of planning for both DMR and DMH. The result is that each agency will have similar three-tier management structures in which client services remain close to the client in the local community but other functions are performed at regional levels to capture economies of scale to the degree possible within each

department. This strategy in part offsets diseconomies attendant to separation itself.

The strategy as it affects the structure includes:

- The number and role of area offices. Costs of duplicating the number of current area offices in each new agency would be prohibitively expensive and imprudent. Populations served by each would be too small to offer the scale required to justify comprehensive service capability. On the other hand, clients and their families justifiably want decisions about their programs made close to home, and want accountable management close by. The proposed organization, with up to 25 local offices in each agency, is an attempt to balance these priorities;

- The structure of regional offices. One DMH management goal, independent of the split, has been to strengthen the regional management structure in order to increase quality, consistency and accountability of service delivery throughout the state. As indicated in Chapter Five, one problem of a highly decentralized management structure is a lack of consistency in program standards and contracting practices throughout the system. Giving regional management greater responsibility for management and development of programs, selection of vendors and negotiation of contracts will make the system more responsive to leadership, and accountable for results. Six regions per department are prudent; this is one less than the current DMH;

- Central office duplication. Central office is where replication is necessary to accomplish independence for each agency, and where costs of separation will be most apparent. Both new agencies will need accounting, financial and budgeting staffs; recruiting, training, labor relations and personnel administration units; MIS and data processing capability; capital budgeting, maintenance and engineering support; planning and policy development groups; legal counsel, legislative liaison, public relations and external communications; internal auditing and investigation, contract administration and monitoring.

  In many of these key functions, while fewer positions are needed to perform the function in the $400 million agency are needed to do it in the $800 million agency, more than half of what currently exists will be necessary in each new agency. For example, the current DMH budget department includes ten staff; perhaps only seven will be needed in each of the new agencies, for a total of fourteen. This requires four new positions. The reason is that even though the total job of

preparing the budget in the new agency might be smaller, measured by "volume" of numbers calculated or some such crude statistic, the complexity of the management issues is still as large as before. A budget director, an assistant director, and a statistical/ computer expert will still be necessary whether they were managing four junior analysts or seven. The cost of replicating central office functions will be approximately $5.8 million over several years.

Timing

Deciding what is needed for two separate, efficiently functioning departments is one thing, and timing of separation is another. Implementation timing as discussed in Chapter Seven foresees a transitional period during which services are shared for various periods of time until each department can carry on independently. Independence is targeted for June 30, 1988, but it is not likely that the full costs of separation will be fully forecast and final budget requests made until FY90 (beginning July, 1989). Thus, financial projections are subject to phasing as are other aspects of the transition. Table 8-1 includes the estimate of the total cost of running two completely independent departments.

As mentioned above and in Chapter Seven, the implementation of this plan will occur gradually over the next 18 months. That plan calls for the phased re-assignment throughout FY88 of existing personnel and other resources to one or the other of the new agencies. The hiring of additional staff required to fill in the gaps in the new organizations mostly will follow the assignment of existing staff. With some important exceptions, this will occur largely during the latter part of FY88 and in FY89. Therefore FY90 will be the first year that the entire cost of the split will fully impact the agencies' operating budgets.

Financing the Split - Perspective

There are currently numerous management and programmatic initiatives underway or being planned within DMH that are independent of the split of the agency. These include the various MR initiatives to develop and enhance its community-based services, thus complementing its already strong facility-based network; the ongoing implementation of the Governor's Mental Health Special Message programs; improvement of contracting systems to ensure greater and consistency in the re-contracting process statewide; development of agency-wide recruitment and training capability; and development of the financial, budgeting, data processing, and other management systems required to operate a modern, professional health care organization.

DMH's current resources do not fully support all of the initiatives outlined above, even absent a split of the agency. Some of them are funded via the Special Message and the Mental Retardation expansion funding. Most of them, including virtually all of the specific management improvements, are only partially funded, if at all.

There has been no attempt to quantify the cost of new resources that would be required, absent a split, to fill in existing gaps in management structure. The cost projections on Table 8-1 show costs of replicating current management capability in the two new agencies. In other words, projected increases are intended to be costs of replacing economies of scale lost as a result of the split, and do not presume addition of new resources that did not exist prior to the split.

Not included either, are costs of ensuring continued service delivery to clients whose needs do not fall neatly into the ambit of either agency. At the moment, since the same area offices are responsible for delivering services to both MH and MR populations within their areas, it is relatively easy for informal arrangements to be made to provide services for clients whose needs may span both sides of the organization. Although ongoing inter-agency cooperation is anticipated after the split, it still may be necessary to formalize a number of programs that are carried out informally now, to ensure that special client populations' needs do not fall between the cracks. These program needs, and the costs associated with them, will be more fully identified during the split transition period.

What remains to be done is development of management support that will enable these professionals to do the work they were hired to do. "Management support" means:

- computer systems and other automated technology, the use of which is currently minimal in most of the hospitals, schools, and other facilities.

- recruitment and training programs for the entire agency;

- consistent personnel policies and procedures throughout the agency;

- capital budgeting and preventive maintenance programs for the hundreds of state buildings, many of them in disrepair, that are under DMH jurisdiction;

- state-of-the-art financial and management controls;

- client accounting and billing systems that will provide the type of accurate and precise cost information that DPW/Medicaid and the Rate Setting Commission require, as

well as allow the agency to have comprehensive client information.

Conclusion

The budget outlined in Table 8-2 has been developed responsibly and conservatively. Agency management is convinced that it reflects a reasonable estimate of the expected cost of carrying out the split as intended in the legislation allocating to both new agencies the resources needed to continue present levels of service and to complete current programmatic and managerial initiatives. The two new agencies, having received legal authority and autonomy, need the resources to carry out their mandates. The figures shown represent the eventual full year cost of supporting two agencies. Funding at these levels will not be necessary in the first or second year of implementation but will be required in FY90. Specific recommendation for adjustments to the FY88 budgets of DMH and DMR are now under review by the Executive Office of Human Services and the Executive Office of Administration and Finance. It is expected that budget amendments will be forwarded to the legislature through the normal process within two weeks.

TABLE 8-1

Projected Costs of Splitting DMH

	Available Resources	Proposed DMR Budget	Proposed DMH Budget
Central	18,624,976	9,807,617	13,954,402
District	4,090,510	7,364,874	5,212,800
Area	11,970,746	7,256,075	6,132,550
TOTAL	34,686,232	24,428,566	25,299,752

Additional Resources Required

Central	$ 5,137,043
District	8,487,164
Area	1,417,879
	$15,042,086

TABLE 8-2

Proposed Budget - Department of Mental Retardation

Central Office

231 Staff	$7,033,040
Support Costs	2,774,577
	$9,807,617

District Office

38 Staff	$1,053,415
Support Costs	174,064
	$1,227,479

Local Service Center

9 Staff	$ 221,490
Support Costs	68,753
	$ 290,243

Total

1 Central Office	$ 9,807,617	231 FTE
6 District Offices	7,364,874	228 FTE
25 Local Service Centers	7,256,075	225 FTE
	$24,428,566	684 FTE

Central Office budget includes agency-wide licensing and legal staff.

Support costs at all levels include such items as office leases, telephones, supplies and equipment, training, and travel expenses.

District and Local Service Center budgets reflect the projected cost of an average office. Some variance among offices at each level is expected.

Local Service Center budgets do not include funds for service coordinator or service coordinator supervisors. The funds for these positions are, and will continue to be, available in the Mental Retardation community program account.

TABLE 8-3

Proposed Budget - Department of Mental Health

Central Office

273 Staff	$ 8,622,758
Support Costs	5,331,644
	$13,954,402

District Office

26 Staff	$ 710,480
Support Costs	158,320
	$ 868,800

Area Office

7 Staff	$ 204,370
Support Costs	40,932
	$ 245,302

Total

1 Central Office	$13,954,402	273 FTE
6 District Offices	5,212,800	156 FTE
25 Area Offices	6,132,550	175 FTE
	$22,869,808	605 FTE

Central Office budget includes agency-wide licensing and legal staff.

Support costs at all levels include such items as office leases, telephones, supplies and equipment, training, and travel expenses.

District and Area budgets reflect the projected cost of an average office. Some variance among offices at each level is expected.

The DMH area reconfiguration proposal includes 23 areas, with Boston as one area. The new DMR area reconfiguration proposal has three areas in Boston. For the purpose of projecting DMH costs, it was assumed that Boston would have resource needs the equivalent of three smaller area offices.

Area budgets do not include funds for case managers. The funds for these positions are, and will continue to be, available in the Mental Health Community Program account.

ACME
BOOKBINDING CO., INC.

JUN 4 1988

100 CAMBRIDGE STREET
CHARLESTOWN, MASS.